Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ / 200 / 2 0 0	
EBID	EBACROS	Month Day EBDATE Year	EBSTFID

YEAR 5 QUESTIONNAIRE

Date of last regularly scheduled contact: ___ / ___ / ____ (Month / Day / Year) ***NOT COLLECTED***

(Interviewer Note: Refer to Data from Prior Visits Report. Please also record this date on the top of page 17.)

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1. In general, how would you say your health is? Would you say it is. . .
(Interviewer Note: Read response options.)

EBHSTAT
① Excellent
② Very good
③ Good
④ Fair
⑤ Poor
⑧ Don't know
⑦ Refused

---

2. Since we last spoke to you about 6 months ago, did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.

EBBED12 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

About how many days did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

EBBEDDAY ___ days

---

3. Since we last spoke to you about 6 months ago, did you cut down on the things you usually do, such as going to work or working around the house, because of an illness or injury? Please include days in bed.

EBCUT12 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

How many days did you cut down on the things you usually do because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

EBCUTDAY ___ days

EBLINK

Page Link # ____

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Draft

4. Since we last spoke to you about 6 months ago, did you stay <u>overnight</u> as a patient in a nursing home or rehabilitation center?

EBMCNH ① Yes ⓪ No ⑧ Don't know ⑦ Refused

5. Since we last spoke to you about 6 months ago, did you receive care at home from a visiting nurse, home health aide, or nurse's aide?

EBMCVN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

6. Since we last spoke to you about 6 months ago, have you had a cold or flu that was bad enough to keep you in bed for all or most of the day?

EBFLU ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. Was your temperature taken?

EBTEMP ① Yes ⓪ No ⑧ Don't know

Go to Question #6b

Was your temperature 100° or higher?

EBTEMPHI ① Yes * ⓪ No ⑧ Don't know

b. Did a doctor or nurse tell you that you had the flu or a fever?

EBFLUDR ① Yes ⓪ No ⑧ Don't know

Interviewer Note: Refer to Data from Prior Visits Report to see if the participant was enrolled in the Flu Substudy within the past 12 months. If they were NOT enrolled in the Flu Substudy within the past 12 months, please complete the Flu Substudy Eligibility Assessment Form.

7. Did you get a flu shot in the past 12 months?

EBFSHOT ① Yes ⓪ No ⑧ Don't know ⑦ Refused

When did you get your most recent flu shot?
If you are unsure, please make your best guess.

EBMOYR ☐☐ / ☐☐☐☐

Month Year

8. Because of a health or physical problem, do you have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?
(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Don't do.")

EBDWQMYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused ⑨ Don't do

→ Go to Question #8d

→ Go to Question #9

a. How much difficulty do you have?
(Interviewer Note: Read response options.)

EBDWQMDF
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it
⑧ Don't know

b. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?
(Interviewer Note: Do NOT read response options. If "some other reason," probe for response. Mark only ONE answer.)

EBMNRS
① Arthritis
② Back pain
③ Balance problems/unsteadiness on feet
④ Cancer
⑤ Chest pain/discomfort
⑥ Circulatory problems
⑦ Diabetes
⑧ Fatigue/tiredness (no specific disease)
⑨ Fall
10 ◯ Heart disease (including angina, congestive heart failure, etc)
11 ◯ High blood pressure/hypertension
12 ◯ Hip fracture
13 ◯ Injury *(Please specify: _____)*
14 ◯ Joint pain
15 ◯ Lung disease (asthma, chronic bronchitis, emphysema, etc)
16 ◯ Old age (no mention of a specific condition)
17 ◯ Osteoporosis
18 ◯ Shortness of breath
19 ◯ Stroke
20 ◯ Other symptom *(Please specify: _____)*
21 ◯ Multiple conditions/symptoms unable to determine MAIN reason
22 ◯ Don't know

c. Do you have any difficulty walking across a small room?

EBDWSMRM ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ **Go to Question #9**

8d. How easy is it for you to walk a quarter of a mile?
(Interviewer Note: Read response options.)

EBDWQMEZ

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/don't do

8e. Because of a health or physical problem, do you have any difficulty walking a distance of one mile, that is about 8 to 12 blocks?

EBDW1MYN

① Yes → Go to Question #9
⓪ No → Go to Question #8f
⑧ Don't know/don't do → Go to Question #8f

8f. How easy is it for you to walk one mile?
(Interviewer Note: Read response options.)

EBDW1MEZ

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/don't do

9. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting?
(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, mark "Yes." If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, mark "Don't do.")

EBDW10YN ① Yes ⓪ No ⑧ Don't know ⑦ Refused ⑨ Don't do

→ ⓪ ⑧ ⑦: Go to Question #9c

→ ⑨: Go to Question #10

a. How much difficulty do you have?
(Interviewer Note: Read response options.)

① A little difficulty
② Some difficulty
EBDIF ③ A lot of difficulty
④ Or are you unable to do it
⑧ Don't know

b. What is the <u>main</u> reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?
(Interviewer Note: Do NOT read response options. If "some other reason," probe for response. Mark only ONE answer.)

EBMNRS2

① Arthritis
② Back pain
③ Balance problems/unsteadiness on feet
④ Cancer
⑤ Chest pain/discomfort
⑥ Circulatory problems
⑦ Diabetes
⑧ Fatigue/tiredness (no specific disease)
⑨ Fall
10 ◯ Heart disease (including angina, congestive heart failure, etc)
11 ◯ High blood pressure/hypertension
12 ◯ Hip fracture
13 ◯ Injury *(Please specify: _____)*
14 ◯ Joint pain
15 ◯ Lung disease (asthma, chronic bronchitis, emphysema,
16 ◯ Old age (no mention of a specific condition)
17 ◯ Osteoporosis
18 ◯ Shortness of breath
19 ◯ Stroke
20 ◯ Other symptom *(Please specify: _____)*
21 ◯ Multiple conditions/symptoms given; unable to determine MAIN reason
22 ◯ Don't know

Go to Question #10

9c. How easy is it for you to walk up 10 steps without resting?
(Interviewer Note: Read response options.)

EBDW10EZ

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/don't do

9d. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

EBDW20YN

① Yes → Go to Question #10
⓪ No → Go to Question #9e
⑧ Don't know/don't do → Go to Question #9e

9e. How easy is it for you to walk up 20 steps without resting?
(Interviewer Note: Read response options.)

EBDW20EZ

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/don't do

10. Do you have to use a cane, walker, crutches, or other special equipment to help you get around?

EBEQUIP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

11. Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?

EBDIOYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Do you usually receive help from another person when you get in and out of bed or chairs?

① Yes ⓪ No ⑧ Don't know **EBDIORHY**

12. Do you have any difficulty bathing or showering?

EBBATHYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Do you usually receive help from another person in bathing or showering?

EBBATHRH ① Yes ⓪ No ⑧ Don't know

13. Do you have any difficulty dressing?

EBDDYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Do you usually receive help from another person in dressing?

EBDDRHYN ① Yes ⓪ No ⑧ Don't know

14. Because of a health or physical problem, do you have any difficulty standing up from a chair without using your arms?

EBDIFSTA ① Yes ⓪ No ⑧ Don't know ⑦ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)

EBDSTAMT
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it
⑧ Don't know

How easy is it for you to stand up from a chair without using your arms?
(Interviewer Note: Read response options.)

EBEZSTA
① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know

15. Do you usually receive help from another person in taking your medications?

EBRHMED ① Yes ⓪ No ⑨ Does not take medications ⑧ Don't know ⑦ Refused

16. Does another person usually help you with managing money?

EBRHBILL ① Yes ⓪ No ⑨ Does not manage money ⑧ Don't know ⑦ Refused

17. Because of a health or physical problem, do you have any difficulty lifting or carrying something weighing 10 pounds, for example a small bag of groceries or an infant?

EBDIF10 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)

EBD10AMT
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it
⑧ Don't know

How easy is it for you to lift or carry something weighing 10 pounds?
(Interviewer Note: Read response options.)

EBEZ10LB
① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know

Do you have any difficulty lifting or carrying something weighing 20 pounds, for example, a large full bag of groceries?

EBD20LBS ① Yes ⓪ No ⑧ Don't know

Go to Question #18

How easy is it for you to lift or carry something weighing 20 pounds?
(***Interviewer Note: Read response options.)***

EBEZ20LB
① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know

18. Did you do heavy or major chores like scrubbing windows or walls, vacuuming, or cleaning gutters; home maintenance activities like painting; gardening or yardwork; or anything like these activities, at least 10 times, in the past 12 months?

EBHC12MO (1) Yes (0) No (8) Don't know (7) Refused

Go to Question #19

a. In the past 7 days, did you do heavy chores or home maintenance activities?

EBHC7DAY (1) Yes (0) No (8) Don't know

Go to Question #19

b. About how much time did you spend doing heavy chores or home maintenance activities in the past 7 days (not counting rest periods)? ***(Interviewer Note: If less than 1 hour, record number of minutes.)***

EBHCHRS ☐☐ Hours ☐☐ Minutes EBHCMINS

(-1) Don't know EBHCDK

19. Did you walk for exercise, or walk to work, the store, or church, or walk the dog, at least 10 times, in the past 12 months?

EBEW12MO ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Go to Question #20

In the past 7 days, did you go walking?

EBEW7DAY ① Yes ⓪ No

a. How many times did you go walking in the past 7 days?

EBEWTIME ☐☐ times

EBEWTMDK ① Don't know

b. About how much time, on average, did you spend walking each time you walked (excluding rest periods)? ***(Interviewer Note: If less than 1 hour, record number of minutes.)***

EBEWHRS ☐☐ Hours **EBEWMINS** ☐☐ Minutes ① Don't know **EBEWTDK**

c. When you walk, do you usually walk at a brisk pace (as fast as you can), a moderate pace, or at a leisurely stroll?

EBEWPACE
① Brisk
② Moderate
③ Stroll
⑧ Don't know

What is the main reason you did not go walking in the past 7 days? ***(Interviewer Note: OPTIONAL - Show card #1.)***

EBEWREAS
① Bad weather
② Not enough time
③ Injury
④ Health problems
⑤ Lost interest
⑥ Felt unsafe
⑦ Not necessary
⑧ Other
⑨ Don't know

20. Did you walk up a flight of stairs (a flight is about 10 steps), at least 10 times, in the past 12 months?

EBFS12MO ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Go to Question #21

a. In the past 7 days, did you walk up a flight of stairs?

EBFS7DAY ① Yes ⓪ No ⑧ Don't know

→ Go to Question #21

b. About how many flights did you walk up in the past 7 days?
If you are unsure, please make your best guess.

EBFSNUM ☐☐☐ flights ① Don't know **EBFSNUMD**

c. About how many of these flights did you walk up carrying a small load like laundry, groceries, or an infant?

EBFSLOAD ☐☐☐ flights ① Don't know **EBFSLODK**

21. Did you do any high intensity exercise, such as bicycling, swimming, jogging, racquet sports or using a stair-stepping, rowing or cross country ski machine or exercycle, at least 10 times, in the past 12 months?

EBHI12MO ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Go to Question #22

In the past 7 days, did you do high intensity exercise activities?

EBHI7DAY ① Yes ⓪ No

a. What activity(ies) did you do?
(Interviewer Note: OPTIONAL - Show card #2. Mark all that apply.)

EBHIABE ① Bicycling/exercycle
EBHIASWM ① Swimming
EBHIAJOG ① Jogging
EBHIAAER ① Aerobics
EBHIASS ① Stair-stepping
EBHIARS ① Racquet sports
EBHIAROW ① Rowing machine
EBHIASKI ① Cross country ski machine
EBHIAOTH ① Other *(Please specify):*

_____

_____

_____

b. In the past 7 days, about how much time did you spend doing *(first activity named by participant)*?
(***Interviewer Note: If less than 1 hour, record number of minutes.)***

EBHIA1HR ☐☐ Hours EBHIA1MN ☐☐ Minutes ① Don't know EBHIA1DK

c. In the past 7 days, about how much time did you spend doing *(second named activity)*?
(Interviewer Note: If less than 1 hour, record number of minutes.)

EBHIA2HR ☐☐ Hours EBHIA2MN ☐☐ Minutes ① Don't know EBHIA2DK

What is the main reason you have not done any high intensity exercise activities in the past 7 days?
(Interviewer Note: OPTIONAL - Show card #3.)

EBHINDEX
① Bad weather
② Not enough time
③ Injury
④ Health problems
⑤ Lost interest
⑥ Felt unsafe
⑦ Not necessary
⑧ Other
⑨ Don't know

Now I'm going to ask you about your physical activity and exercise habits when you were around 50 years old.

Thinking back to when you were around 50 years old--the late 1960's to early 1970's; the Vietnam War era...

22. In a typical week, did you do any regular walking--for exercise, to get to work, while at work, to walk the dog--for at least one hour per week?

EBEW50 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Did you do regular walking for at least three hours per week?

EBEW50H3 ① Yes ⓪ No ⑧ Don't know

23. In a typical week, did you participate in any vigorous exercise or sports, such as bicycling, swimming, jogging, or racquet sports, for at least one hour per week?

EBHI50 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Did you participate in any vigorous exercise or sports for at least three hours per week?

EBHI50H3 ① Yes ⓪ No ⑧ Don't know

APPETITE, WEIGHT CHANGE, and SMOKING STATUS

Now I have some questions about your appetite.

24. In general, would you say that your appetite or desire to eat has been. . . ?
(Interviewer Note: Read response options.)

EBAPPET
① Very good
② Good
③ Moderate
④ Poor
⑤ Very poor
⑧ Don't know
⑦ Refused

25. Since we last spoke to you about 6 months ago, has your weight changed by 5 or more pounds?
(Interviewer Note: We are interested in net gain or loss during the past 6 months. In other words, i
the participant currently either 5 or more pounds heavier or lighter than they were 6 months ago.)

EBCHN5LB ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. Did you gain or lose weight?
(Interviewer Note: We are interested in net gain or loss during the past 6 months.)

EBGNLS ① Gain ② Lose ⑧ Don't know

b. Were you trying to gain/lose weight?

EBTRGNLS ① Yes ⓪ No ⑧ Don't know

26. At the present time, are you trying to lose weight?

EBTRYLS2 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

27. Do you currently smoke cigarettes?

EBSMOKE ① Yes ⓪ No ⑧ Don't know ⑦ Refused

On the average, about how many cigarettes a day do you smoke?

EBSMOKAV ☐☐ cigarettes per day

MEDICAL CONDITIONS

Now I'm going to ask you about some medical problems that you might have had in the past 12 months.

In the past 12 months, has a doctor told you that you had...?

28. Hypertension or high blood pressure? We are specifically interested in hearing about hypertension or high blood pressure that was diagnosed for the first time in the past 12 months.

EBHCHBP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

29. Diabetes or sugar diabetes? Again, we are specifically interested in hearing about diabetes that was diagnosed for the first time in the past 12 months.

EBSGDIAB ① Yes ⓪ No ⑧ Don't know ⑦ Refused

30. In the past 12 months, have you fallen and landed on the floor or ground?

EBAJFALL ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Go to Question #31

How many times have you fallen in the past 12 months?
If you are unsure, please make your best guess.

EBAJFNUM ① One ② Two or three ④ Four or five ⑥ Six or more ⑧ Don't know

31. Are you troubled by shortness of breath when hurrying on a level surface or walking up a slight hill?

EBLCSBUP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

32. Do you ever have to stop for breath when walking at your own pace on a level surface?

EBLCSBLS ① Yes ⓪ No ⑧ Don't know ⑦ Refused

33. Do you have to walk slower than people your own age when on a level surface because of breathlessness?

EBLCSBWS ① Yes ⓪ No ⑧ Don't know ⑦ Refused

34. During the past 12 months, were there times when you had a cough almost every morning?

EBCOF ① Yes ⓪ No ⑧ Don't know ⑦ Refused

How often did you have this morning cough?
(Interviewer Note: The months do not have to be consecutive.)

EBCOFNUM
① A total of 3 or more months out of the past 12 months
② Less than 3 months out of the past 12 months
⑧ Don't know

35. In the past 12 months, have you had wheezing or whistling in your chest at any time?

EBWHZ ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Did you require medicine or treatment for any of the times you had wheezing or whistling in your chest?

EBWHZMED ① Yes ⓪ No ⑧ Don't know

36. Has a doctor ever told you that you had asthma?

EBLCASTH ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. Do you still have asthma?

EBLCSHA ① Yes ⓪ No ⑧ Don't know

b. Have you had an attack of asthma in the past 12 months?

EBLCAS12 ① Yes ⓪ No ⑧ Don't know

37. In the past 12 months, have you gone to a doctor's office or hospital emergency room for asthma or breathing problems?

EBLCASHP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

38. Has a doctor ever told you that you had any of the following...?

a. Emphysema?

EBLCEMPH ① Yes ⓪ No ⑧ Don't know ⑦ Refused

b. Chronic obstructive pulmonary disease or COPD?

EBLCCOPD ① Yes ⓪ No ⑧ Don't know ⑦ Refused

c. Chronic bronchitis?

EBLCCHBR ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Do you still have chronic bronchitis?

EBLCSHCB ① Yes ⓪ No ⑧ Don't know

MEDICAL CONDITIONS IN PAST 6 MONTHS

Now I'm going to ask you about any medical problems you might have had since we last spoke to you about 6 months ago, which was on ☐☐ / ☐☐ / ☐☐☐☐ Month Day Year ***NOT COLLECTED***

39. Since we last spoke to you about 6 months ago, has a doctor told you that you had a heart attack, angina, or chest pain due to heart disease?

EBHCHAMI ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Were you hospitalized overnight for this problem?

EBHOSMI ① Yes ⓪ No → Go to Question #40

Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a. ☐☐☐☐☐ **EBREF39A**

b. ☐☐☐☐☐ **EBREF39B**

c. ☐☐☐☐☐ **EBREF39C**

40. Since we last spoke to you about 6 months ago, has a doctor told you that you had congestive heart failure?

EBCHF ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Were you hospitalized overnight for this problem?

EBHOSMI3 ① Yes ⓪ No → Go to Question #41

Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a. ☐☐☐☐☐ **EBREF40A**

b. ☐☐☐☐☐ **EBREF40B**

c. ☐☐☐☐☐ **EBREF40C**

41. Since we last spoke to you about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **EBHCCVA**

Were you hospitalized overnight for this problem?

EBHOSMI2 ① Yes ⓪ No → Go to Question #42

Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a. ☐☐☐☐☐ **EBREF41A**

b. ☐☐☐☐☐ **EBREF41B**

c. ☐☐☐☐☐ **EBREF41C**

42. Since we last spoke to you about 6 months ago, has a doctor told you that you had cancer? We are specifically interested in hearing about a cancer that your doctor diagnosed for the first time since we last spoke to you.

EBCHMGMT ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. [ ][ ][ ][ ][ ] **EBREF42A**
b. [ ][ ][ ][ ][ ] **EBREF42B**
c. [ ][ ][ ][ ][ ] **EBREF42C**

43. Since we last spoke to you about 6 months ago, has a doctor told you that you had pneumonia?

EBLCPNEU ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. [ ][ ][ ][ ][ ] **EBREF43A**
b. [ ][ ][ ][ ][ ] **EBREF43B**
c. [ ][ ][ ][ ][ ] **EBREF43C**

44. Since we last spoke to you about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

EBOSBR45 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. [ ][ ][ ][ ][ ] **EBREF44A**
b. [ ][ ][ ][ ][ ] **EBREF44B**
c. [ ][ ][ ][ ][ ] **EBREF44C**

45. Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?

EBHOSP12 (1) Yes (0) No (8) Don't know (7) Refused

Complete a Health ABC Event Form, Section I, for each event.
Record reference #'s and reason for hospitalization below.

a. EBREF45A Reason for hospitalization: _____

b. EBREF45B Reason for hospitalization: _____

c. EBREF45C Reason for hospitalization: _____

d. EBREF45D Reason for hospitalization: _____

e. EBREF45E Reason for hospitalization: _____

f. EBREF45F Reason for hospitalization: _____

46. Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?

EBOUTPA (1) Yes (0) No (8) Don't know (7) Refused

Was it for. . .?

Reference #

a. A procedure to open a blocked artery — (1) Yes (0) No (8) Don't know → ***Complete a Health ABC Event Form, Section III. Record reference #:*** EBBLART — EBREF46A

b. Gall bladder surgery — (1) Yes (0) No (8) Don't know — EBGALLBL

c. Cataract surgery — (1) Yes (0) No (8) Don't know — EBCATAR

d. Hernia repair (Inguinal abdominal hernia.) — (1) Yes (0) No (8) Don't know — EBHERN

e. TURP (MEN ONLY) (transurethral resection of prostate) — (1) Yes (0) No (8) Don't know — EBTURP

f. Other — (1) Yes (0) No (8) Don't know — EBOTH

Please specify the type of outpatient surgery.

i. _____

ii. _____

iii. _____

47. Is there any other illness or condition for which you see a doctor or other health care professional?

EBOTILL ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Go to Question #48

Please describe for what:

_____

_____

_____

_____

48. This next question refers to the past month. In the past month, on the average, have you been feeling unusually tired during the day?

EBELTIRE ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Have you been feeling unusually tired...?
(Interviewer Note: Read response options.)

EBELOFTN
① All of the time
② Most of the time
③ Some of the time
⑧ Don't know

49. During the past month, how weak did you feel? Using this card, please choose the best category, where 0 is "not weak at all" and 10 is "very weak."
(Interviewer Note: REQUIRED - Show card #4.)

EBWLEV ☐☐ Weakness level ⑧ Don't know ⑦ Refused **EBWLEVRF**

50. During the past month, how sleepy did you feel during the day? Using this card, please choose the best category, where 0 is "not sleepy at all" and 10 is "very sleepy."
(Interviewer Note: REQUIRED - Show card #5.)

EBSLEV ☐☐ Sleepy level ⑧ Don't know ⑦ Refused **EBSLEVRF**

51. During the past month, how lively did you feel? Using this card, please choose the best category, where 0 is "not lively at all" and 10 is "very lively."
(Interviewer Note: REQUIRED - Show card #6.)

EBLLEV ☐☐ Lively level ⑧ Don't know ⑦ Refused **EBLLEVRF**

52. During the past month, how tired did you feel? Using this card, please choose the best category, where 0 is "not tired at all" and 10 is "very tired."
(Interviewer Note: REQUIRED - Show card #7.)

EBTLEV ☐☐ Tired level ⑧ Don't know ⑦ Refused **EBTLEVRF**

53. Using this card, please choose the category that best describes your usual energy level in the past month on a scale of 0 to 10 where 0 is no energy and 10 is the most energy that you have ever had.
(Interviewer Note: REQUIRED - Show card #8.)

EBELEV ☐☐ Energy level ⑧ Don't know ⑦ Refused **EBELEVRF**

54. How many hours of sleep do you usually get at night?

EBSHHRS ☐☐ hours ⑧ Don't know ⑦ Refused EBSHHRS2

55. During a usual week, how many times do you nap for 5 minutes or more?
(Interviewer Note: Write in "0" if participant does not take any naps.)

EBSHNAPS ☐☐ naps ⑧ Don't know ⑦ Refused EBSHNPS2

56. Please indicate how often you experience each of the following:
(Interviewer Note: Read one question at a time. REQUIRED - Show card #9.)

	Never (0)	Rarely (Once per month or less)	Sometimes (2 to 4 times per month)	Often (5 to 15 times per month)	Almost Always (16 to 30 times per month)	Don't know	Refused
a) Have trouble falling asleep.	⓪	①	②	③	④	⑧	⑦
b) Wake up during the night and have difficulty getting back to sleep.	⓪	①	②	EBSHTFS ③	④	⑧	⑦
c) Wake up too early in the morning and be unable to get back to sleep.	⓪	①	②	EBSHWUDN ③	④	⑧	⑦
d) Feel excessively (overly) sleepy during the day.	⓪	①	②	EBSHWUTE ③	④	⑧	⑦
e) Take sleeping pills or other medication to help you sleep.	⓪	①	②	EBSHFESD ③ EBSHMED	④	⑧	⑦

57. Now I have some questions about your feelings during the past week. For each of the following statements, please tell me if you felt that way: Rarely or None of the time; Some of the time; Much of the time; Most or All of the time.
(Interviewer Note: REQUIRED - Show card #10.)

		Rarely or None of the time (<1 day)	Some of the time (1-2 days)	Much of the time (3-4 days)	Most or All of the time	Don't know	Refused
a. I was bothered by things that usually don't bother me.	EBFBOTHR	①	②	③	④	⑧	⑦
b. I had trouble keeping my mind on what I was doing.	EBFMIND	①	②	③	④	⑧	⑦
c. I was depressed.	EBFDOWN	①	②	③	④	⑧	⑦
d. I felt that everything I did was an effort.	EBFEFFRT	①	②	③	④	⑧	⑦
e. I felt hopeful about the future.	EBFHOPE	①	②	③	④	⑧	⑦
f. I felt fearful.	EBFFEAR	①	②	③	④	⑧	⑦
g. My sleep was restless.	EBFSLEEP	①	②	③	④	⑧	⑦
h. I was happy.	EBFHAPPY	①	②	③	④	⑧	⑦
i. I felt lonely.	EBFLONE	①	②	③	④	⑧	⑦
j. I could not get going.	EBFNOGO	①	②	③	④	⑧	⑦

58. Has a close friend or family member had a serious accident or illness in the past 12 months?

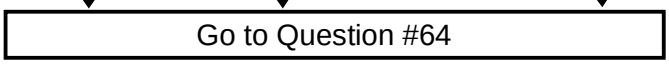
EBLEACC ① Yes ⓪ No ⑧ Don't know ⑦ Refused

59. Did a child, grandchild, close friend, or relative die in the past 12 months?
(Interviewer Note: The death of a spouse or partner should only be recorded in the next question, Question #60.)

EBLERDIE ① Yes ⓪ No ⑧ Don't know ⑦ Refused

60. Did your spouse or partner die in the past 12 months?

EBLESDIE ① Yes ⓪ No ⑧ Don't know ⑦ Refused



61. Please tell me which best describes how you've been feeling lately.
Interviewer Note: REQUIRED - Show card # 11.)

		Never	Rarely	Sometimes	Often	Always	Refused
a.	I think about this person so much that it's hard for me to do the things I normally do.	EBLETHNK 0	1	2	3	4	7
b.	Memories of the person who died upset me.	EBLEMEM 0	1	2	3	4	7
c.	I feel I cannot accept the death of the person who died.	EBLEACPT 0	1	2	3	4	7
d.	I feel myself longing for the person who died.	EBLELONG 0	1	2	3	4	7
e.	I feel drawn to places and things associated with the person who died.	EBLEDRWN 0	1	2	3	4	7
f.	I can't help feeling angry about his/her death.	EBLEANGR 0	1	2	3	4	7
g.	I feel disbelief over what happened.	EBLEDISB 0	1	2	3	4	7
h.	I feel stunned or dazed over what happened.	EBLEDAZE 0	1	2	3	4	7
i.	Ever since s/he died it is hard for me to trust people.	EBLETRST 0	1	2	3	4	7
j.	Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about.	EBLEDIST 0	1	2	3	4	7
k.	I have pain in the same area of my body or have some of the same symptoms as the person who died.	EBLEPAIN 0	1	2	3	4	7
l.	I go out of my way to avoid reminders of the person who died.	EBLEAVD 0	1	2	3	4	7
m.	I feel that life is empty without the person who died.	EBLEEMPT 0	1	2	3	4	7
n.	I hear the voice of the person who died speak to me.	EBLESPK 0	1	2	3	4	7
o.	I see the person who died stand before me.	EBLESTND 0	1	2	3	4	7
p.	I feel that it is unfair that I should live when this person died.	EBLELIVE 0	1	2	3	4	7
q.	I feel bitter over this person's death.	EBLEBITR 0	1	2	3	4	7
r.	I feel envious of others who have not lost someone close.	EBLEENV 0	1	2	3	4	7
s.	I feel lonely a great deal of the time ever since s/he died.	EBLELONE 0	1	2	3	4	7

62. Using this card, where 0 is extremely unhappy and 10 is very happy, please tell me how happy you are?
(Interviewer Note: REQUIRED - Show card #12.)

EBSSHAPY ☐☐ ⑧ Don't know ⑦ Refused **EBSSHADR**

---

63. Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with the meaning and purpose of your life?
(Interviewer Note: REQUIRED - Show card #13.)

EBSSMEAN ☐☐ ⑧ Don't know ⑦ Refused **EBSFMDR**

---

64. Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with how often you see or talk to your family and friends?
(Interviewer Note: REQUIRED - Show card #13.)

EBSSFFST ☐☐ ⑧ Don't know ⑦ Refused **EBSSFFDR**

---

65. Using this card, where 0 is extremely dissatisfied and 10 is very satisfied, how satisfied are you with the help you get from your family and friends, for example, helping in an emergency, fixing your house, or doing errands?
(Interviewer Note: REQUIRED - Show card #13.)

EBSSFFH ☐☐ ⑧ Don't know ⑦ Refused **EBSFHDR**

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66. In the <u>past year</u>, could you have used more emotional support than you received?

EBSSESPY ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Would you say you needed a lot more, some more, or a little more?

EBSSEAM

① A lot more
② Some more
③ A little more
⑧ Don't know

---

67. Have you changed your doctor or place that you usually go for health care or advice about your health care in the past 12 months?

EBHCADV
① Yes
⓪ No
⑧ Don't know
⑦ Refused
② I don't have a doctor or place that I usually go for health care

Go to Question #68

a. Where do you usually go for health care or advice about health care?
(Interviewer Note: Read response options. Mark only ONE answer.)

EBHCSRC
① Private doctor's office (individual or group practice)
② Public clinic such as a neighborhood health center
③ Health Maintenance Organization (HMO) *(Please specify: _____)*
(Examples: Security Blue, US Healthcare, Health America, The Apple Plan, Omnicare, Prucare)
④ Hospital outpatient clinic
⑤ Emergency room
⑥ Other *(Please specify: _____)*

b. ***Interviewer Note: Please update the name, address, and telephone number of the doctor or place that the participant usually goes to for health care on the HABC Participant Contact Information report.***

68. In addition to Medicare, are you currently covered by any other federal government health insurance programs such as Medicaid, CHAMPUS/VA or other military programs?

EBFEDINS (1) Yes (0) No (8) Don't know (7) Refused

Go to Question #69

What federal government health insurance program are you covered by?

(1) Medicaid (Tenncare in Tennessee)

EBINPROG (2) CHAMPUS or CHAMP-VA (health insurance for family members of military personnel)

(3) Other ***(Please specify:)***

_____

69. In addition to Medicare, do you have a health insurance plan, Medigap, or other supplemental coverage which pays for any part of a hospital, doctor's or surgeon's bill?

EBSUPCOV (1) Yes (0) No (8) Don't know (7) Refused

Go to Question #70

What type of health insurance do you have?
(Interviewer Note: Please record all types below.)

EBPRIVIN -1 (1) Private insurance (Examples: Blue Cross, Prudential)

(Please specify): _____

EBHMO -1 (1) Health Maintenance Organization (sometimes referred to as an HMO)

(Please specify): _____

EBMGP -1 (1) Medigap

EBINOTH -1 (1) Other

(Please specify): _____

70. In addition to Medicare, do you have any health insurance plan that pays for prescription medicines?

EBINMED (1) Yes (0) No (8) Don't know (7) Refused

The next set of questions deals with income and family economic situations. Health ABC is a study of health but research shows that income and resources can affect health in ways that are sometimes important and surprising. We are asking a few questions for this reason.

71. The following question refers to your personal family income for the last year including all sources such as wages, salaries, Social Security or retirement benefits, help from relatives, rent from property and so forth.

Was it more than $25,000?

EBFIIN25 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

$10,000 or more?

EBFIIN10 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. $50,000 or more?

EBFIIN50 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

b. $100,000 or more?

EBFIINC ① Yes ⓪ No ⑧ Don't know ⑦ Refused

72. How well does the amount of money you (and your husband/wife/partner) have take care of your needs -- poorly, fairly well, or very well?

EBFIFIN

① Poorly

② Fairly well

③ Very well

⑧ Don't know

⑦ Refused

73. In the past 12 months, have you delayed getting medical care because of money problems?

EBFIMCAR ① Yes ⓪ No ⑧ Don't know ⑦ Refused

74. In the past 12 months, have you gone without medications you needed because of money problems?

EBFIMEDS ① Yes ⓪ No ⑧ Don't know ⑦ Refused

CURRENT ADDRESS AND TELEPHONE NUMBER

75. We would like to update all of your contact information this year. The address that we currently have listed for you is:
(Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the address you have for the participant is correct.)

Is the address that we currently have correct?

◯ Yes ◯ No ***NOT COLLECTED***

Interviewer Note: Please record the street address, city, state and zip code for the participant on the HABC Participant Contact Information report.

76. The telephone number(s) that we currently have for you is (are):
(Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the telephone number(s) that you have for the participant are correct.)

Please tell me if these telephone number(s) are correct.

Are the telephone number(s) that we currently have correct?

◯ Yes ◯ No ***NOT COLLECTED***

Interviewer Note: Please record the telephone number(s) for the participant on the HABC Participant Contact Information report.

77. Do you expect to move or have a different address in the next 6 months?

◯ Yes ◯ No ◯ Don't know ◯ Refused ***NOT COLLECTED***

Interviewer Note: Please record the new mailing address, and telephone number, and date the new address and telephone numbers are effective on the HABC Participant Contact Information report.

78. You previously told us the name of someone who could provide information and answer questions for you in the event that you were unable to answer for yourself. Please tell me if the information I have is still correct.
(Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for someone who could provide information and answer questions for the participant is correct.)

Is the contact information for someone who could provide information and answer questions for the participant correct?

Yes ○ → Go to Question #79

No ○ → ***NOT COLLECTED***

Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number on the HABC Participant Contact Information report. Please determine whether this person is next of kin or has power of attorney.

79. You previously told us the name, address, and telephone number of two close friends or relatives who do not live with you and who would know how to reach you in case you move and we need to get in touch with you. These people did not have to be local people. Please tell me if the information I have is still correct.
(Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for two close friends or relatives who do not live with the participant is correct.)

Is the contact information for the two close friends or relatives who do not live with the participant and who would know how to reach the participant in case they move correct?

Yes ○ → Go to Question #80

No ○ → ***NOT COLLECTED***

Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number on the HABC Participant Contact Information report. Please determine whether this person is next of kin or has power of attorney.

80. Has the participant identified their next of kin?
(Interviewer Note: Refer to the HABC Participant Contact Information report.)

NOT COLLECTED ○ Yes ○ No ○ Don't know ○ Refused

No / Don't know → Go to Question #81

Refused → Go to Question #82

Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for the next of kin is correct.

You previously told us the name and address of your next of kin. Please tell me if the information I have is still correct.

Is the name and address of the next of kin correct?

NOT COLLECTED ○ Yes ○ No ○ Don't know ○ Refused

Yes → Go to Question #82

Refused → Go to Question #82

Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.

Go to Question #82

81. Please tell me the name, address, and telephone number of your next of kin.
How is this person related to you?

Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.

82. Has the participant identified their power of attorney?
(Interviewer Note: Refer to the HABC Participant Contact Information report.)

NOT COLLECTED ○ Yes ○ No ○ Don't know ○ Refused

No / Don't know → Go to Question #83

Refused → Go to Question #84

Interviewer Note: Please review the HABC Participant Contact Information report and confirm that the contact information for the power of attorney is correct.

You previously told us the name and address of your power of attorney. Please tell me if the information I have is still correct.

Is the name and address of the power of attorney correct?

NOT COLLECTED ○ Yes ○ No ○ Don't know ○ Refused

Yes → Go to Question #84

Refused → Go to Question #84

Interviewer Note: Please record the name, street address, city, state, zip code, and telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.

Go to Question #84.

83. Have you given anyone power of attorney?

○ Yes ○ No ○ Don't know ○ Refused ***NOT COLLECTED***

Interviewer Note: Please record the name, street address, city, state, zip code, telephone number, and how the person is related to the participant on the HABC Participant Contact Information report.

84. ***Interviewer Note: Please answer the following question based on your judgment of the participant's responses to this questionnaire.***

On the whole, how reliable do you think the participant's responses to this questionnaire are?

EBRELY

① Very reliable

② Fairly reliable

③ Not very reliable

⑧ Don't know

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ / 200 /	
E1ID	E1ACROS	Month Day E1DATE Year	E1STFID

YEAR 5 CLINIC VISIT WORKBOOK

Arrival Time: : E1TIME1 (Hours Minutes)

Departure Time: : E1TIME2 (Hours Minutes)

YEAR 5 CLINIC VISIT PROCEDURE CHECKLIST

Measurement	Page #	Yes: Measurement fully completed	Yes: Measurement partially completed	No: Participant refused	No: Other reason/ Not applicable	Comments
1. Year 5 Questionnaire		1	3	0	2	E1Y5ADM
2. Medication inventory update	2	1	3	0	2	E1MIF
3. Weight	7	1	3	0	2	E1WT
4. Blood pressure	7	1	3	0	2	E1BP
5. Bone density (DXA) scan	8	1	3	0	2	E1DXA
6. Ultrasound	11	1	3	0	2	E1BUA
7. Assessment of arthritis, knee, and hip pain	15	1	3	0	2	E1KNPAIN
8. Knee crepitus	20	1	3	0	2	E1KNCREP
9. 20-meter walk	21	1	3	0	2	E120M
10. Isokinetic ankle strength	22	1	3	0	2	E1ISO
11. Pulmonary function test	26	1	3	0	2	E1PFT
12. Teng mini-mental state	29	1	3	0	2	E1TMM
13. Digit symbol substitution	35	1	3	0	2	E1DSS
14. CLOX 1	37	1	3	0	2	E1CLOX
15. Hearing	38	1	3	0	2	E1HEAR
16. Was the Cognitive Vitality Substudy Workbook completed?		1	3	0	2	E1COGVIT
17. Was the Flu Substudy Workbook completed?		1	3	0	2	E1FLU
18. Did participant agree to schedule a knee x-ray?		1		0	2	E1KNXR
19. Did participant agree to schedule a knee MRI?		1		0	2	E1KNMRI

Memphis Only:

Would you like us to send a copy of your test results to your doctor? 1 Yes 0 No E1DOC

E1LINK

Page Link #

Annotated 4/17/2001 pjm
Y5CVW Version 1.0, 4/6/2001 pjm

Draft

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H MAID/MIFID	MAACROS	MIFMDATE/MADATE Month Day Year	MASTAFF

YEAR 5 MEDICATION INVENTORY FORM -- Page A

Section A Medication Reception

Collect all prescription and over-the-counter medications used in the previous two weeks. Refer to *Data From Prior Visits Report*. Ask if the participant has used each prescription and over-the-counter medication listed on *Data From Prior Visits Report* within the past 2 weeks. Record on the *Medication Inventory Form* all prescription and over-the-counter medications (including pills, dermal patches, eye drops, creams, salves, and injections) used in the previous two weeks, even if already listed on the *Data From Prior Visits Report*. Record the complete drug name exactly as written on the container label. Confirm strength, units, number used, etc.

Are these all the prescription and over-the-counter medications that you took during the last two weeks? We are also interested in drugs not usually prescribed by a doctor, such as supplements, vitamins, pain medications, laxatives or bowel medicines, cold medications, cough medications, antacids or stomach medicines, and ointments or salves.

MAMEDS [1] Yes [0] No [2] Took no prescription or non-prescription medicines

MATOTAL Total number brought in: ____

Did examiner call participant to complete MIF? [1] Yes [0] No MACALL

Section B Prescription Medication.

Copy the name of the prescription, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken PRN ("as needed basis"), and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M (1 2 3)	MIFPRN [1] Y [0] N	MIFSEEN [1] Y [0] N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	[1] Rx MIFRX [0] Non Rx
2.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N
	Reason for use:			Date Started: Month Year	Formulation Code:	[ ] Rx [ ] Non Rx
3.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N
	Reason for use:			Date Started: Month Year	Formulation Code:	[ ] Rx [ ] Non Rx
4.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N
	Reason for use:			Date Started: Month Year	Formulation Code:	[ ] Rx [ ] Non Rx
5.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N
	Reason for use:			Date Started: Month Year	Formulation Code:	[ ] Rx [ ] Non Rx

Health ABC

YEAR 5 MEDICATION INVENTORY FORM -- Page B

Section B Prescription Medication -- Continued

	Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? *Check "X": Yes or No*	Container Seen? *Check "X": Yes or No*
6.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M (1 2 3)	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR	Formulation Code: MIFFORM	1 Rx MIFRX 0 Non Rx
7.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
8.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
9.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
10.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
11.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
12.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx

☐ Continued on MIF Supplement

Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Page Link # ☐

YEAR 5 MEDICATION INVENTORY FORM -- Page C

Section C Over-the-counter Medications and Supplements

Copy the name of the over-the-counter medicine, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken PRN ("as needed basis") and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH (1) / MIFYEAR (2 3) Month Year	Formulation Code: MIFFORM	MIFRX 1 Rx 0 Non Rx
2.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
3.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
4.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
5.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
6.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx
7.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx ☐ Non Rx

YEAR 5 MEDICATION INVENTORY FORM -- Page D

Section C Over-the-counter Medications and Supplements -- Continued

	Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
8.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M (1 2 3)	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	1 Rx 0 Non Rx MIFRX
9.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month Year	Formulation Code:	Rx Non Rx
10.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month Year	Formulation Code:	Rx Non Rx
11.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month Year	Formulation Code:	Rx Non Rx
12.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month Year	Formulation Code:	Rx Non Rx
13.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month Year	Formulation Code:	Rx Non Rx
14.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month Year	Formulation Code:	Rx Non Rx

☐ Continued on MIF Supplement

Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H _____ MAID/MIFID	_____ MAACROS	___ / ___ / _____ MIFDATE/MADATE (Month / Day / Year)	_____ MASTAFF

YEAR 5 MEDICATION INVENTORY FORM

SUPPLEMENT

Prescription and Over-the-counter Medications and Supplements

Copy the name of the prescription or over-the-counter medicine, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken PRN ("as needed" basis) and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1S.	MIFNAME	MIF STREN	MIF UNIT	____ MIFDWM D (1) W (2) M (3)	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	1 Rx 0 Non Rx MIFRX
2S.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx ☐ Non Rx
3S.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx ☐ Non Rx
4S.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx ☐ Non Rx
5S.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx ☐ Non Rx
6S.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx ☐ Non Rx
7S.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx ☐ Non Rx

Health ABC

HABC Enrollment ID #	Acrostic
H	

WEIGHT

E1WTK ___.___ kg

E1STFID2 Staff ID# ___

BLOOD PRESSURE

❶ Cuff Size ④ Small ① Regular ② Large ③ Thigh **E1OCUF**

❷ Arm Used **E1ARMRL** ① Right ② Left → ***Please explain why right arm was not used:*** _____ _____

(Examiner Note: Refer to Data from Prior Visits Report.)

Pulse Obliteration Level

❸ Palpated Systolic **E1POPS** ___ mm Hg

Add 30*

❹ Maximal Inflation Level (MIL) ___ † mm Hg **E1POMX**

* ***Add +30 to Palpated Systolic to obtain Maximal Inflation Level.***

† ***If MIL is ≥ 300 mm Hg, repeat the MIL. If MIL is still ≥ 300 mm Hg, terminate blood pressure measurements.***

❺ Was blood pressure measurement terminated because MIL was ≥ 300 mm Hg after second reading?

E1BPYN ① Yes ⓪ No

Sitting Blood Pressure

❻ Systolic **E1SYS** ___ mm Hg

❼ Diastolic **E1DIA** ___ mm Hg

Comments (required for missing or unusual values): _____ _____ _____

E1STFID3 Staff ID# ___

HABC Enrollment ID #	Acrostic	Staff ID #
H		

E1STFID4

BONE DENSITY (DXA) SCAN

1 Do you have breast implants?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1BI**

- ◆ Flag scan for review by DXA Reading Center.
- ◆ Indicate in the table in Question #4 whether breast implant is in "Left ribs" or "Right ribs" subregion, or both.

2 Have you ever had a hip replacement surgery where all or part of your joint was replaced?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1HIPRP**

On which side did you have hip replacement surgery?

① Right → Do NOT scan right hip.

② Left → Do NOT scan left hip.

③ Both **E1HIPRP2** → Do NOT scan either hip. Go to Question #4 on page 9.

3 Which hip was scanned at the Baseline (Year 1) Clinic Visit?
(Examiner Note: Refer to Data from Prior Visits Report to see which hip was scanned at Baseline.)

E1HIPY1

① Right → Scan right hip unless contraindicated.

② Left → Scan left hip unless contraindicated.

③ Neither → Scan right hip unless contraindicated.

⑧ Don't know → Scan right hip unless contraindicated.

❹ Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1MO**

a. Flag scan for review by DXA Reading Center.

b. Indicate in the table the location of joint replacement, hardware or other artifacts (sub-regions are those defined by the whole body scan analysis.)

Sub-region	Hardware	Other Artifacts	None	
Head	①	②	⑨	**E1HEAD**
Left arm	①	②	⑨	**E1LA**
Right arm	①	②	⑨	**E1RA**
Left ribs	①	②	⑨	**E1LR**
Right ribs	①	②	⑨	**E1RR**
Thoracic spine	①	②	⑨	**E1TS**
Lumbar spine	①	②	⑨	**E1LS**
Pelvis	①	②	⑨	**E1PEL**
Left leg	①	②	⑨	**E1LL**
Right leg	①	②	⑨	**E1RL**

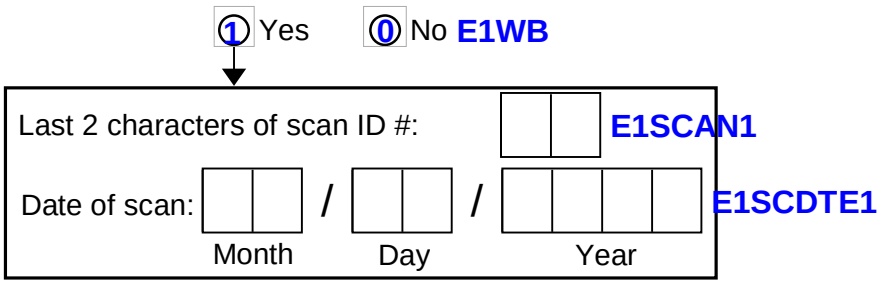
❺ Have you had any of the following tests within the past ten days?

	Yes	No	
a. Barium enema	① *	⓪	**E1BE**
b. Upper GI X-ray series	① *	⓪	**E1UGI**
c. Lower GI X-ray series	① *	⓪	**E1LGI**
d. Nuclear medicine scan	① *	⓪	**E1NUKE**
e. Other tests using contrast ("dye") or radioactive materials	① *	⓪	**E1OTH2**

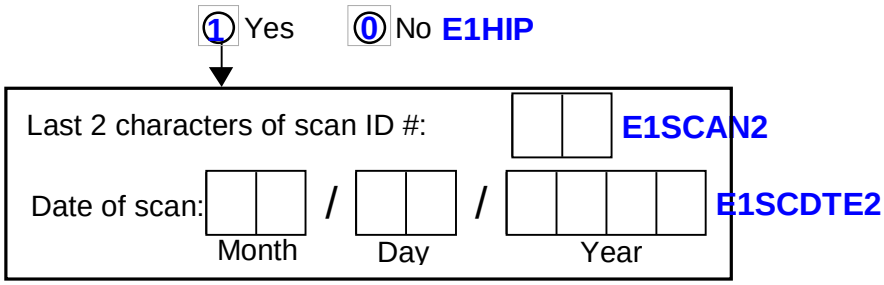
(*Examiner Note: If "Yes" to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)

❻ Was a bone density measurement obtained for...?

a. Whole body



b. Hip



ULTRASOUND

E1STFID5

1 Does the participant have a cast or an open sore on either foot?

1 Yes

0 No **E1CAST**

Which foot?

1 Right

Have you ever broken your left heel bone?

E1BKLHL 1 Yes

Do NOT scan. Go to Question #6.

0 No

Scan left foot. Go to Question #6.

2 Left

Have you ever broken your right heel bone?

E1BKRHL 1 Yes

Do NOT scan. Go to Question #6.

0 No

Scan right foot. Go to Question #6.

3 Both **E1CASTFT**

Do NOT scan. Go to Question #6.

2 Have you ever broken your heel bone?
(Examiner Note: We are NOT interested in any other fractures, such as foot, ankle, or leg fractures.)

1 Yes

0 No

8 Don't know

7 Refused **E1BKHL**

Which foot...right, left, or both?

1 Right

Scan left foot. Go to Question #6.

2 Left

Scan right foot. Go to Question #6.

3 Both **E1HLLRB**

Do NOT scan. Go to Question #6.

❸ Which heel was scanned at Year 2?
(Examiner Note: Refer to Data from Prior Visits Report.)

① Right → Scan right foot. Go to Question #6.

② Left → Scan left foot. Go to Question #6.

⓪ Neither **E1Y2HEEL**

❹ Have you broken any bone in your leg, ankle, or foot in the past 12 months?
(Examiner Note: Do not include isolated toe fractures.)

① Yes

⓪ No

⑧ Don't know

⑦ Refused **E1BKBONE**

Which ankle, leg, or foot?

① Right → Scan left foot. Go to Question #6.

② Left

⑧ Don't know → Scan right foot. Go to Question #6.

③ Both **E1BKLRB**

Which side was most recently broken?

E1BKSIDE ① Right → Scan left foot. Go to Question #6.

② Left

⑧ Don't know

③ Both → Scan right foot. Go to Question #6.

Draft

Page Link #

Annotated 4/17/2001 pjm
Y5CVW Version 1.0, 4/6/2001 pjm

5 Do you have any permanent weakness in your legs, ankles or feet from an old injury or stroke?

E1WKLEGS ① Yes

⓪ No

⑧ Don't know

⑦ Refused

Scan right foot and go to Question #6.

Which side is weaker?

E1SIDEWK

① Right — Scan left foot. Go to Question #6.

② Left — Scan right foot. Go to Question #6.

③ Right and left are equally weak — Scan right foot. Go to Question #6.

6 Which foot was scanned?

E1BUSCAN

① Right

② Left

③ Scan not attempted

④ Scan not completed

Why wasn't the scan attempted?

E1BUCOMP

① Participant refused
② Equipment problem
③ Foot too big/edema/deformity
⑤ Heel fracture
⑥ Open sore
⑦ Cast
④ Other

(Please specify: _____)

Why wasn't the scan completed?

E1BUNOSC

① Out of range reading
② Invalid measurement
③ Other

(Please specify: _____)

7 Measurement #1:

QUI ___.___ **E1BUQUI1** units

BUA ___.___ **E1BUBUA1** units → Did BUA result have an asterisk? ① Yes ⓪ No **E1BUAST1**

SOS ____.___ **E1BUSOS1** m/s

Measurement #2:

QUI ___.___ **E1BUQUI2** units

BUA ___.___ **E1BUBUA2** units → Did BUA result have an asterisk? ① Yes ⓪ No **E1BUAST2**

SOS ____.___ **E1BUSOS2** m/s

8 What is the difference between BUA measurement #1 and BUA measurement #2?

___.___ **E1BUDIF1** units

a. Was the difference between BUA measurement #1 and BUA measurement #2 ≥ 10 units?

① Yes ⓪ No **E1BUDIF2**

↓

Repeat scan and record results in section #9 below.

b. Did both BUA measurement #1 and BUA measurement #2 have an asterisk?

① Yes ⓪ No **E1BU2AST**

↓

Repeat scan and record results in section #9 below.

9

QUI ___.___ **E1BUQUI3** units

BUA ___.___ **E1BUBUA3** units → Did BUA result have an asterisk? ① Yes ⓪ No **E1BUAST3**

SOS ____.___ **E1BUSOS3** m/s

HABC Enrollment ID #	Acrostic	Staff ID #
H		

E1STFID6

ASSESSMENT OF ARTHRITIS and KNEE PAIN

1 In the past 12 months, has a doctor told you that you have osteoarthritis or degenerative arthritis? We are specifically interested in learning about osteoarthritis or degenerative arthritis that was diagnosed for the first time in the past 12 months.

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJARTH**

a.	Did the doctor say it was...?	
i.	Osteoarthritis or degenerative arthritis in your knee?	① Yes ⓪ No ⑧ Don't know **E1AJKNEE**
ii.	Osteoarthritis or degenerative arthritis in your hip?	① Yes ⓪ No ⑧ Don't know **E1AJHIP**
b.	Do you take any medicines for arthritis or joint pain?	① Yes ⓪ No ⑧ Don't know **E1AJMEDS**

Now I am going to ask you some questions regarding any pain or stiffness in your joints. I will also examine your knees.

These questions are about pain, aching or stiffness in or around your knee. This includes the front, back and sides of the knee.

First, I'll ask about your left knee.

2 In the past 12 months, have you had any pain, aching or stiffness in your left knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJLK12**

In the past 12 months, have you had pain, aching or stiffness in your left knee on most days for at least one month?

① Yes * ⓪ No ⑧ Don't know **E1AJLK1M**

Examiner Note: Refer to back to this question when completing Question #10. Participant may be eligible for knee x-ray.

3 Now, please think about the past 30 days. In the past 30 days, have you had any pain, aching or stiffness in your left knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJLK30**

a. In the past 30 days, have you had pain, aching or stiffness in your left knee on most days?

① Yes * ⓪ No ⑧ Don't know **E1AJLKMS**

b. In the past 30 days, how much pain have you had in your left knee for each activity I will describe. How much pain have you had while...?
(Examiner Note: Read each activity separately. Read response options. OPTIONAL-Show Card A.)

	None	Mild	Moderate *	Severe *	Extreme *	Don't know	
a) Walking on a flat surface	⓪	①	② *	③ *	④ *	⑧	**E1AJLKFS**
b) Going up or down stairs	⓪	①	② *	③ *	④ *	⑧	**E1AJLKST**
c) At night while in bed	⓪	①	② *	③ *	④ *	⑧	**E1AJLKBD**
d) Standing upright	⓪	①	② *	③ *	④ *	⑧	**E1AJLKUP**
e) Getting in or out of a chair ***(Examiner Note: A relatively hard, supportive chair)***	⓪	①	② *	③ *	④ *	⑧	**E1AJLKCH**
f) Getting in or out of a car	⓪	①	② *	③ *	④ *	⑧	**E1AJLKIN**

* ***Examiner Note: Refer back to this question when completing Question #10. Participant may be eligible for knee x-ray.***

ASSESSMENT OF KNEE PAIN (RIGHT KNEE)

Now I am going to ask about your right knee.

4 In the past 12 months, have you had any pain, aching or stiffness in your right knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJRK12**

In the past 12 months, have you had pain, aching or stiffness in your right knee on most days for at least one month?

① Yes * ⓪ No ⑧ Don't know **E1AJRK1M**

* ***Examiner Note: Refer to back to this question when completing Question #10. Participant may be eligible for knee x-ray.***

5 Please think about the past 30 days. In the past 30 days, have you had any pain, aching or stiffness in your right knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJRK30**

a. In the past 30 days, have you had pain, aching or stiffness in your right knee on most days?

① Yes * ⓪ No ⑧ Don't know **E1AJRKMS**

b. In the past 30 days, how much pain have you had in your right knee for each activity I will describe. How much pain have you had while...?

Examiner Note: Read each activity separately. Read response options. OPTIONAL-Show Card A.

	None	Mild	Moderate *	Severe *	Extreme *	Don't know	
a) Walking on a flat surface	⓪	①	② *	③ *	④ *	⑧	**E1AJRKFS**
b) Going up or down stairs	⓪	①	② *	③ *	④ *	⑧	**E1AJRKST**
c) At night while in bed	⓪	①	② *	③ *	④ *	⑧	**E1AJRKBD**
d) Standing upright	⓪	①	② *	③ *	④ *	⑧	**E1AJRKUP**
e) Getting in or out of a chair ***(Examiner Note: A relatively hard, supportive chair)***	⓪	①	② *	③ *	④ *	⑧	**E1AJRKCH**
f) Getting in or out of a car	⓪	①	② *	③ *	④ *	⑧	**E1AJRKIN**

* ***Examiner Note: Refer back to this question when completing Question #10. Participant may be eligible for knee x-ray.***

6 In the past 30 days, have you limited your activities because of pain, aching or stiffness in your knees?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJACT**

On how many days did you limit your activities because of pain, aching or stiffness?

E1AJLDAY ☐☐ days ⑧ Don't know **E1AJLDDK**

7 In the past 30 days, have you changed, cut back, or avoided any activities in order to avoid knee pain or reduce the amount of knee pain?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJCUT**

HIP PAIN

8 Now I am going to ask you a question about pain in your hip. In the past 12 months, have you had hip pain on <u>most days</u> for <u>at least one month</u>? This includes pain in the groin and either side of the upper thigh. Do <u>not</u> include pain that was only in your lower back or buttocks.
(Examiner Note: REQUIRED - Show Card B.)

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1AJH30D**

⓪ No, ⑧ Don't know, ⑦ Refused → Go to Question #9

① Yes →

In the past 12 months, have you had this pain in the right hip, left hip or both hips?

E1AJH12M

② Right hip only

① Left hip only

③ Both right and left hip

9 Is the participant eligible for a follow-up knee x-ray?

(Examiner Note: Refer to Data from Prior Visits Report.)

E1KNELIG (1) Yes (0) No

Schedule knee x-ray.

(Examiner Note: Explain knee OA substudy and schedule participant for a knee x-ray. Go to Question # 11.)

10 Did the participant have knee symptoms that met eligibility criteria for a knee x-ray in Year 2, Year 3, or Year 4?

(Examiner Note: Refer to Data from Prior Visits Report.)

E1KSYMP (1) Yes

a. Does the participant have knee symptoms at this Year 5 clinic visit?

(Examiner Note: Review Questions #2, #3, #4, and #5 on pages 15,16, & 17 -- participant must have at least one asterisked "*" answer.)

(1) Yes

(0) No **E1KSYY5A**

STOP.

b. Did the participant have a knee x-ray in Year 2, Year 3, or Year 4?

(Examiner Note: Refer to Data from Prior Visits Report.)

(1) Yes

(0) No **E1KXY234**

Do NOT schedule x-ray.

Schedule knee x-ray.

(0) No

Does the participant have knee symptoms at this Year 5 clinic visit?

(Examiner Note: Review Questions #2, #3, #4, and #5 on pages 15,16, & 17 -- participant must have at least one asterisked "*" answer.)

(1) Yes

Schedule knee x-ray.

(0) No **E1KSY5B**

Do NOT schedule knee x-ray.

11 Is the participant eligible for a follow-up knee MRI?

(Examiner Note: Refer to Data from Prior Visits Report.)

E1MRIFU (1) Yes (0) No

Do NOT schedule MRI.

Schedule knee MRI.

(Examiner Note: Explain knee OA substudy and schedule participant for a knee MRI.)

KNEE CREPITUS

HABC Enrollment ID #	Acrostic	Staff ID #
H		

E1STFID7

Examiner Note: If participant has an artificial leg or total knee replacement, do not test for knee crepitus on that side. Crepitus is defined as palpable continuous noise or grinding sensation (series of small clicks, pops, or grinding similar to sandpaper scratching sensation). Place your palm over the participant's patella. Ask the participant to actively move their leg to a full extended position (zero degrees) twice, then rest a moment, then twice more.

1 Have you had a knee replacement in your right knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1KNREP**

→ Do not examine right knee. Go to Question #3.

2 Is there crepitus in the right knee?

E1AJCRPR

⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason (e.g., artificial leg)

Consensus with 2nd examiner

E1RN2EX

⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason

E12EXID1
2nd examiner Staff ID#:

3 Have you had a knee replacement in your left knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1KNREPL**

→ Do not examine left knee.

4 Is there crepitus in the left knee?

E1AJCRPL

⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason (e.g., artificial leg)

Consensus with 2nd examiner

E1LN2EX

⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason

E12EXID2
2nd examiner Staff ID#:

Examiner Note: If the participant cannot fully extend their leg, assist them by holding the leg at the ankle and pumping through a full range of motion.

20-METER WALK

❶ Describe the 20-meter walk.

Script: "This is a two part walking test. The first part tests your usual walking speed. When you go past the orange cone, I want you to stop."

Examiner Note: Demonstrate how to walk past the cone.

"Now, wait until I say 'Go'. For the first part of this test, I want you to walk at your usual walking pace. Any questions?"

❷ *To start the test, say,*

Script: "Ready, Go."

❸ *Begin timing and counting participant's steps until their first footfall over the finish line at 20 meters. You will need to walk a few steps behind the participant. Start timing with the first footfall over the starting line (participant's foot touches the floor on the first step).*

When the participant reaches the 20-meter mark, push the right-hand STA/STP button on the stop watch, and record the number of steps taken. You will need to carry the form on a clipboard.

Number of steps for usual-pace 20-meter walk: ☐☐ **E120STP1** steps

E120MW1
⑦ Participant refused
⑨ Not attempted, unable
① Attempted, unable to complete

(Examiner Note: Do not record time.)

Record the time it took to do the usual-pace 20-meter walk.

Time on stop watch: **E120TM1A** ☐ : ☐☐ . ☐☐ **E120TM1B**
Min Second Hundredths/Sec

Reset the stop watch and have the participant repeat the 20-meter walk by walking back to the starting line. Instruct the participant to walk as quickly as they can for the second portion of the test.

Script: "OK, fine. Now turn around and when I say go, walk back the other way as fast as you can. Ready, Go."

When the participant reaches the starting line, push the right-hand STA/STP button on the stop watch, and record the number of steps taken.

Number of steps for fast-pace 20-meter walk: ☐☐ **E120STP2** steps

E120MW2
⑦ Participant refused
⑨ Not attempted, unable
① Attempted, unable to complete

(Examiner Note: Do not record time.)

Record the time it took to do the fast-pace 20-meter walk.

Time on stop watch: **E120TM2A** ☐ : ☐☐ . ☐☐ **E120TM2B**
Min Second Hundredths/Sec

❹ Was the participant using a walking aid, such as a cane?
① Yes ⓪ No **E1WLKAID**

HABC Enrollment ID #	Acrostic	Staff ID #
H		

E1STFID9

ANKLE STRENGTH (KIN-COM)

Exclusion Criteria

1 Is the participant's sitting blood pressure greater than 199 mm Hg (systolic) or greater than 109 mm Hg (diastolic)?

(Examiner Note: Refer to Blood Pressure Form, page 7.)

① Yes ⓪ No ⑧ Don't know **E1BP2**

→ Do NOT test. Go to Question #10.

---

2 Script: "First I need to ask you a few questions to see if you should try the test."

Has a doctor ever told you that you had an aneurysm in the brain?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1ANEU**

→ Do NOT test. Go to Question #10.

---

3 Has a doctor told you that you had a cerebral hemorrhage (bleeding in the brain) in the last six months?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1CERHEM**

→ Do NOT test. Go to Question #10.

---

4 Have you ever had ankle surgery on your right leg where all or part of the ankle joint was replaced or fused?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E1ANKSUR**

→ Do NOT test. Go to Question #10.

---

5 Have you ever had an injury that has made one leg weaker than the other?
(Examiner Note: Do not change leg tested based on this question.)

1 Yes 0 No 8 Don't know 7 Refused **E1INYN**

Which leg is stronger?
1 Right leg 2 Left leg 8 Don't know **E1WKR**

6 Is it difficult for you to bend either of your ankles fully due to pain, arthritis, injury, or some other condition?
(Examiner Note: Do not change leg tested based on this question. First try the Manual Test to determine if Kin-Com exam can be performed.)

1 Yes 0 No 8 Don't know 7 Refused **E1ANKBND**

Which ankle?
1 Right ankle 2 Left ankle 3 Both ankles **E1ANKLRB**

Manual Test

7 Was the right leg tested?

(1) Yes

(0) No, Manual Test not performed **E1RLEG**

Please explain why:

_____

_____

_____

Examiner Note: Put hands above the participant's foot and ask the participant to pull up with their toes against your hands. Keep your elbows extended and use the weight of your upper body to resist the pull.

After having tried the movement, the participant should be asked:

8 Did you have pain in your ankle that stopped you from pulling hard?

(1) Yes → Do NOT test. Go to Question #10.

(0) No **E1ANKPN** → Administer Kin-Com exam. Go to Question #9.

9 **Manual Positioning Settings**

a. Dynamometer tilt **E1DTLT** ___ °

b. Dynamometer rotation **E1DROT** ___ °

c. Lever arm green C stop **E1LEVGR** ___

d. Lever arm red D stop **E1LEVRD** ___

e. Seat rotation **E1STROT** ___ °

f. Seat back angle **E1STBK** ___ °

g. Seat bottom depth **E1STBOT** ___ cm

h. Seat bottom angle **E1STBOTA** ___ °

i. Lever arm length **E1LENGTH** ___ cm

ANKLE STRENGTH (KIN-COM)

j. Maximum isometric effort to determine starting force:

for plantarflexion E1MAXFCP [ ][ ][ ] ÷ 2 = [ ][ ][ ] E1STFORP → Enter as Start Force for plantarflexion

for dorsiflexion E1MAXFCD [ ][ ][ ] ÷ 2 = [ ][ ][ ] E1STFORD → Enter as Start Force for dorsiflexion

Plantarflexion

10 **a.** Was the plantarflexion test performed?

① Yes ⓪ No

E1PFLEX

Cross off as each trial is completed:
[1][2][3][4][5][6]

1. How many trials were attempted? [ ] trials E1TRATP

2. Were three curves accepted?
① Yes ⓪ No E1CURVP

a. Why not? _____

_____

b. How many curves were accepted? E1TRACP [ ] accepted

3. Peak Torque [ ][ ][ ] E1PKTRQP Nm

4. Average Torque [ ][ ][ ] E1AVTRQP Nm

5. Coefficient of variation (cv) E1CVP [ ][ ] % E1CVPRF ① Not applicable (fewer than 3 curves)

6. Was an extra record saved?
① Yes ⓪ No E1EXRECP

How many accepted curves were saved in extra record? [ ] E1CURVSP curves

Why wasn't the test done? **(Examiner Note: Mark all that apply.)**

E1EECP ① Participant excluded based on eligibility criteria

E1RFP ① Participant refused

E1OTEXP ① Other

Dorsiflexion

b. Was the dorsiflexion test performed?

① Yes ⓪ No

E1DFLEX

Cross off as each trial is completed:
[1][2][3][4][5][6]

1. How many trials were attempted? [ ] trials E1TRATD

2. Were three curves accepted?
① Yes ⓪ No E1CURVD

a. Why not? _____

_____

b. How many curves were accepted? E1TRACD [ ] accepted

3. Peak Torque [ ][ ][ ] E1PKTRQD Nm

4. Average Torque [ ][ ][ ] E1AVTRQD Nm

5. Coefficient of variation (cv) E1CVD [ ][ ] % E1CVDRF ① Not applicable (fewer than 3 curves)

6. Was an extra record saved?
① Yes ⓪ No E1EXRECD

How many accepted curves were saved in extra record? [ ] E1CURVSD curves

Why wasn't the test done? **(Examiner Note: Mark all that apply.)**

E1EECD ① Participant excluded based on eligibility criteria

E1RFD ① Participant refused

E1OTEXD ① Other

11 What is the Kin-Com file name? [ ][ ][ ][ ] E1KCFILE .CHA
(Examiner Note: Please refer to the top of the printout.)

PULMONARY FUNCTION TEST TRACKING

1 Is the participant's systolic blood pressure greater than 199 mm Hg or diastolic blood pressure greater than 109 mm Hg?
Examiner Note: Check the Blood Pressure data collection form (page #7 in Year 5 Clinic Visit Workbook).

E2BPCHK ① Yes ⓪ No

→ Do NOT test. Go to Question # 8.

2 Have you had any surgery on your chest or abdomen in the past 2 months?

E2SURG ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Do NOT test. Go to Question # 8.

3 Have you had a heart attack in the past 2 months?

E2HA ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Do NOT test. Go to Question # 8.

4 Now please think about the past 30 days. Have you been hospitalized for any other heart problem in the past 30 days?

E2HOSP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Do NOT test. Go to Question # 8.

5 Do you have a detached retina or have you had eye surgery in the past 2 months?

E2RET ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Do NOT test. Go to Question # 8.

6 Have you had symptoms of a cold or respiratory infection within the past 2 weeks?

E2RESP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

7 Does the participant regularly use beta-agonist inhalers, an anticholinergic inhaler (Atrovent), or a combination inhaler (Combivent)?

Examiner Note: Check Medication Inventory Form or sack of medications being carried by participant. Common beta-agonist inhalers include: Short acting: Albuterol, Brethair, Maxair Autohaler, Proventil, Tornalate, Ventolin. Long acting: Serevent. Anticholinergic inhaler: Atrovent. Combination inhaler: Combivent.

E2BETA ① Yes ⓪ No ⑧ Don't know

Has the participant used their . . .

- Short-acting inhaler (e.g., Albuterol, Brethair, Maxair Autohaler, Proventil, Tornalate, Ventolin), in the last 4 hours
- Atrovent or Combivent in the last 6 hours, or
- Serevent in the last 10 hours?

(Examiner Note: If a participant has used Atrovent, Combivent, or Serevent, within the proscribed time period, they should NOT be asked to use their short-acting bronchodilator.)

E2INHALE ① Yes ⓪ No ⑧ Don't know

① Yes	⓪ No	⑧ Don't know
Administer PFT and go to Question # 8.	If the participant has their short-acting bronchodilator with them, ask them to take two puffs and wait 15 minutes before performing the test. If they do not have their short-acting bronchodilator with them, proceed with the test.	Administer PFT and go to Question # 8.

8 Was the MIP test completed?

① Yes

Record the participant's three highest maximal inspiratory pressures:

MIP1:	**E2MIP1** ☐☐☐	cm H_2O
MIP2:	**E2MIP2** ☐☐☐	cm H_2O
MIP3:	**E2MIP3** ☐☐☐	cm H_2O

⓪ No **E2MIP**

Why wasn't the MIP test completed?
(Examiner Note: Mark all that apply.)

- **E2MIPEQ** ① Equipment failure
- **E2MIPUU** ① Participant unable to understand instructions
- **E2MIPME** ① Participant medically excluded
- **E2MIPUC** ① Participant physically unable to cooperate
- **E2MIPRF** ① Participant refused
- **E2MIPOT** ① Other

(Please specify:)

_____

_____

9 Was the spirometry test completed?

1 Yes

Record the results:

E2FVCBS FVC Best value: ☐☐.☐☐ liters

E2FVCPR FVC Percent predicted: ☐☐☐.☐ percent

E2FEVBST FEV_1 Best value: ☐.☐☐ liters

E2FEVPR FEV_1 Percent predicted: ☐☐☐.☐ percent

E2FEVPR2 FEV_1/FVC%: ☐☐☐.☐ percent

0 No **E2SPIR**

Why wasn't the spirometry test completed?
(Examiner Note: Mark <u>all</u> that apply.)

E2PFTEQ 1 Equipment failure

E2PFTUU 1 Participant unable to understand instructions

E2PFTME 1 Participant medically excluded

E2PFTUC 1 Participant physically unable to cooperate

E2PFTRF 1 Participant refused

E2PFTOT 1 Other ***(Please specify:)***

_____

_____

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ / 200 / Month Day Year E2DATE	E2STFID2

COGNITIVE FUNCTION

Teng Mini-Mental State Exam

Are you comfortable? I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once.

(Examiner Note: Record responses. If the participant does not answer, mark the "No response" option.)

1 When were you born? E2BORNRF

a. ___ / b. ___ / c. ___ ① No response

Month Day Year

E2BORNM E2BORND E2BORNY

Where were you born? (Place of Birth?)

	Answer given	Can't do/ Refused	Not attempted/ disabled
E2CITY d. City/town	①	⑦	③
E2STE e. State/Country	①	⑦	③

Examiner Note: Ask again in Question #18.

2 I am going to say three words for you to remember. Repeat them after I have said all three words:

Shirt, Blue, Honesty

(Examiner Note: Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned. Do not record response until after the last presentation.)

	Correct	Error/ Refused	Not attempted/ disabled
a. Shirt E2SHRT	①	⑦	③
b. Blue E2BLU	①	⑦	③
c. Honesty E2HON	①	⑦	③

d. Numbers of presentations necessary for the participant to repeat the sequence: ___ E2NUM presentations

3 a. I would like you to count from 1 to 5.

① Able to count forward ② Unable to count forward *Say 1-2-3-4-5* E2CNT

b. Now I would like to you count backwards from 5 to 1. Record the responses in the order given: ***(Examiner Note: Enter "99999" if no response)***

E2CNTBK ___ ___ ___ ___ ___

4 a. Spell "world."

① Able to spell ② Unable to spell "It's spelled W-O-R-L-D." E2SPL

b. Now spell "world" backwards

(Examiner Note: Record letter in order given. Enter "xxxxx" if no response.)

E2SPWLD ___ ___ ___ ___ ___

5 What three words did I ask you to remember earlier?

(Examiner Note: The words may be repeated in any order. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices, score "Unable to recall/refused" and provide the correct answer.)

a. Shirt

E2SHRM
- 1 Spontaneous recall
- 2 Correct word/incorrect form
- 3 After "Something to wear"
- 4 After "Was it shirt, shoes, or socks?"
- 7 Unable to recall/refused (provide the correct answer)
- 6 Not attempted/disabled

b. Blue

E2BLRM
- 1 Spontaneous recall
- 2 Correct word/incorrect form
- 3 After "A color"
- 4 After "Was it blue, black, or brown?"
- 7 Unable to recall/refused (provide the correct answer)
- 6 Not attempted/disabled

c. Honesty

E2HNRM
- 1 Spontaneous recall
- 2 Correct word/incorrect form
- 3 After "A good personal quality"
- 4 After "Was it honesty, charity, or modesty?"
- 7 Unable to recall/refused (provide the correct answer)
- 6 Not attempted/disabled

6 **a.** What is today's date?
(Examiner Note: If the participant does not answer, mark the "No response" option.)

E2TDAYM Month / E2TDAYD Day / E2TDAYY Year

1 No response — E2TDAYRF

b. What is the day of the week?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

E2DAYWK — Day of the week

c. What season of the year is it?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

E2SEAS — Season

7 **a.** What state are we in?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

E2STAT — State

b. What county are we in?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

E2CNTY — County

c. What (city/town) are we in?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

E2CITN — City/town

d. Are we in a clinic, store, or home?
(Examiner Note: If correct answer is not among the three alternatives [e.g., hospital or nursing home], substitute it for the middle alternative [store]. If the participant states that none is correct, ask them to make the best choice of the three options.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

E2WHRE

8 ***(Examiner Note: Point to the object or a part of your own body and ask the participant to name it. Score "Error/Refused" if the participant cannot name it within 2 seconds or gives an incorrect name. Do not wait for the participant to mentally search for the name.)***

	Correct	Error/ Refused	Not attempted/ disabled
a. Pencil: What is this?	1	7	3
E2PENC			
b. Watch: What is this?	1	7	3
E2WTCH			
c. Forehead: What do you call this part of the face?	1	7	3
E2FRHD			
d. Chin: And this part?	1	7	3
E2CHIN			
e. Shoulder: And this part of the body?	1	7	3
E2SHLD			
f. Elbow: And this part?	1	7	3
E2ELP			
g. Knuckle: And this part?	1	7	3
E2KNK			

9 What animals have four legs?
Tell me as many as you can.

(Examiner Note: Discontinue after 30 seconds. Record the total number of correct responses. If the participant gives no response in 10 seconds and there are still at least 10 seconds remaining, gently remind them [once only]).
"What (other) animals have four legs?"
The first time an incorrect answer is provided, say,
"I want four-legged animals."
Do not correct for subsequent errors.

Score (total correct reponses): ☐☐ E2SCR

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

(Examiner Note: Write any additional correct answers on a separate sheet of paper.)

10 ***(Examiner Note: If the initial response is scored "Lesser correct answer" or "Error," coach the participant by saying: "An arm and a leg are both limbs or extremities" to reinforce the correct answer. Coach only for Question #10a. No other prompting or coaching is allowed.)***

a. In what way are an arm and a leg alike?

E2ARLG
1 Limbs, extremities, appendages
2 Lesser correct answer (e.g., body parts, both bend, have joints)
7 Error/refused (e.g., states differences, gives unrelated answer)
3 Not attempted/disabled

b. In what way are laughing and crying alike?

E2LCRY
1 Expressions of feelings, emotions
2 Lesser correct answer (e.g., sounds, expressions, other similar responses)
7 Error/refused (e.g., states differences, gives unrelated answer)
3 Not attempted/disabled

c. In what way are eating and sleeping alike?

E2ETSL
1 Necessary bodily functions, essential for life
2 Lesser correct answer (e.g., bodily functions, relaxing, good for you or other similar responses)
7 Error/refused (e.g. states differences, gives unrelated answer)
3 Not attempted/disabled

11 Repeat what I say: **"I would like to go out."**
(Examiner Note: Pronounce the individual words distinctly but with normal tempo of a spoken sentence.)

E2RPT
1 Correct
2 1 or 2 words missed
7 3 or more words missed/refused
3 Not attempted/disabled

12 Now repeat: **"No ifs, ands or buts."**

(Examiner Note: Pronounce the individual words distinctly but with normal tempo of a spoken sentence. Give no credit if the participant misses the "s.")

	Correct	Error/ Refused	Not attempted/ disabled
a. no ifs	1	7	3
		E2IF	
b. ands	1	7	3
		E2AND	
c. or buts	1	7	3
		E2BUT	

13 ***Examiner Note: Hold up Card C and say,***
"Please do this."

If the participant does not close their eyes within 5 seconds, prompt by pointing to the sentence and saying

"Read and do what this says."

If the participant has already read the sentence aloud spontaneously, simply say,

"Do what this says."

Allow 5 seconds for the response. Assign the appropriate score (see below). As soon as the participant closes their eyes, say

"Open."

E2CRD1
- 1 Closes eyes without prompting
- 2 Closes eyes after prompting
- 3 Reads aloud, but does not close eyes
- 7 Does not read aloud or close eyes/refused
- 5 Not attempted/disabled

14 Please write the following sentence:
I would like to go out.

(Examiner Note: Hand participant a piece of blank paper and a #2 pencil with eraser. If necessary, repeat the sentence word by word as the participant writes. Allow a maximum of 1 minute after the first reading of the sentence for scoring the task. Either printing or cursive writing is allowed. Score "Correct" for each correct word, but no credit for "I". For each word, score "Error/Refused" if there are spelling errors or incorrect mixed capitalizations (all letters printed in uppercase are permissible). Self-corrected errors are acceptable.)

	Correct	Error/ Refused	Not attempted/ disabled
a. would	1	7	3
		E2WLD	
b. like	1	7	3
		E2LKE	
c. to	1	7	3
		E2TO	
d. go	1	7	3
		E2GO	
e. out	1	7	3
		E2OUT	

(Examiner Note: Note which hand the participant uses to write. If this task is not done, ask participant if they are right or left handed. [Use in Question #16])

E2HAND
- 1 Right
- 2 Left
- 8 Unknown

15 Here is a drawing. Please copy the drawing onto this piece of paper.

(Examiner Note: Hand participant Card D. Allow 1 minute for copying. For right-handed participants, present the sample on the left side; for left-handed participants, present the sample on the right side. Allow a maximum of 1 minute for response. Do not penalize for self-corrected errors, tremors, minor gaps, or overshoots.)

a. Pentagon 1

E2PENT1

① 5 approximately equal sized
② 5 sides, but longest:shortest side is >2:1
③ nonpentagon enclosed figure
④ 2 or more lines, but it is not an enclosed figure
⑦ less than 2 lines/refused
⑥ not attempted/disabled

b. Pentagon 2

E2PENT2

① 5 approximately equal sized
② 5 sides, but longest:shortest side is >2:1
③ nonpentagon enclosed figure
④ 2 or more lines, but it is not an enclosed figure
⑦ less than 2 lines/refused
⑥ not attempted/disabled

c. Intersection

E2INT

① 4-cornered enclosure
② not a 4-cornered enclosure
⑦ no enclosure/refused
④ not attempted/disabled

16 ***(Examiner Note: Refer to Question #14 to check whether the participant is right- or left-handed. Ask them to take the paper in their non-dominant hand.)***

"Take this paper with your left (right for left handed person) hand, fold it in half using both hands, and hand it back to me."

(Examiner Note: After saying the whole command, hold the paper within reach of the participant. Do not repeat any part of the command. Do not move the paper toward the participant. The participant may hand back the paper with either hand.)

	Correct	Error/ Refused	Not attempted/ disabled
a. Takes paper in correct hand	①	⑦	③
E2PCOR			
b. Folds paper in half	①	⑦	③
E2PFLD			
c. Hands paper back	①	⑦	③
E2PHND			

17 What three words did I ask you to remember earlier?

(Examiner Note: Administer this item even when the participant scored one or more "unable to recall/refused" on Question #5. The words may be repeated in any order. For each word not readily given, provide the category followed by multiple choices when necessary. Do not wait more than 3 seconds for spontaneous recall and do not wait more than 2 seconds after category cueing before providing the next level of help.)

a. Shirt

E2SH2
- ① Spontaneous recall
- ② Correct word/incorrect form
- ③ After "Something to wear"
- ④ After "Was it shirt, shoes, or socks?"
- ⑦ Unable to recall/refused (provide the correct answer)
- ⑥ Not attempted/disabled

b. Blue

E2BLU2
- ① Spontaneous recall
- ② Correct word/incorrect form
- ③ After "A color"
- ④ After "Was it blue, black, or brown?"
- ⑦ Unable to recall/refused (provide the correct answer)
- ⑥ Not attempted/disabled

c. Honesty

E2HON2
- ① Spontaneous recall
- ② Correct word/incorrect form
- ③ After "A good personal quality"
- ④ After "Was it honesty, charity, or modesty?"
- ⑦ Unable to recall/refused (provide the correct answer)
- ⑥ Not attempted/disabled

18 Would you please tell me again where you were born?

(Examiner Note: Ask this question only when a response was given in Question #1d and #1e. Score the response by checking against the response in Question #1d and #1e.)

Place of Birth?		Matches	Does not match/ Refused	Not attempted/ disabled
a. _____ City/town	E2CITY2	①	⑦	③
b. _____ State/Country	E2STE2	①	⑦	③

19 ***(Examiner Note: If physical/functional disabilities or other problems exist which cause the participant difficulty in completing any of the tasks, record the nature of the problem listed below. Mark <u>all</u> that apply.)***

- E2VIS -1 Vision
- E2HEAR -1 Hearing
- E2WRITE -1 Writing problems due to injury or illness
- E2ILLIT -1 Illiteracy or lack of education
- E2LANG -1 Language
- E2OTH -1 Other ***(Please record the specific problem in the space provided.)***

_____

HABC Enrollment ID #	Acrostic	Staff ID #
H		

E2STFID3

DIGIT SYMBOL SUBSTITUTION

❶ *Determine if participant wears glasses for reading.*

Script: "Do you usually wear glasses to read?" E2GLS ① Yes → Ask the participant to put on their glasses.

⓪ No

❷ *Place the task sheet before the participant and point to the task.*

Script: "Look at these boxes across the top of the page. On the top of each box is a number from one through nine. On the bottom part of each box there is a symbol. Each symbol is paired with a number."

❸ *Point to the four rows of boxes.*

Script: "Down here are boxes with numbers on the top, but the bottom part is blank. What I want you to do is to put the correct symbol in each box like this."

❹ *Fill in the first three sample boxes.*

Script: "Now I want you to fill in all boxes up to this line."

❺ *Point to the line separating the samples from the test proper.*

E2TST

① Sample completed → Go on to timed test.

② Unable to complete sample → Do NOT go on to timed test. Write in "00" below for Number Completed and "00" for Number Incorrect.

⑦ Refused

③ Unable to test (arthritis, poor vision, etc.)

→ Do NOT go on to timed test. Do not score.

Script: "When I tell you to begin, start here and fill in the boxes in these four rows. Do them in order and don't skip any. Please try to work as quickly as possible. Let's begin."

Stop the participant after 90 seconds. Say:

Script: "That's good. That completes this set of tasks."

Score: ***(Examiner Note: Use Card E to score test.***
DO NOT COUNT ANY SYMBOLS AFTER TWO BLANKS IN A ROW)

E2NC Number Completed: ☐☐

E2NI Number Incorrect: ☐☐

Examiner Note: Place a plain white sheet of paper in front of the participant and say:

Script: "Draw me a clock that says 1:45. Set the hands and numbers on the face so that a child could read them."

1.	Does figure resemble a clock?	1 Yes 0 No	**E2CLX01**
2.	Is a circular face present?	1 Yes 0 No	**E2CLX02**
3.	Are the dimensions >1 inch?	1 Yes 0 No	**E2CLX03**
4.	Are all numbers inside the perimeter?	1 Yes 0 No	**E2CLX04**
5.	Is there sectoring or are there tic marks?	1 Yes 0 No	**E2CLX05**
6.	Were 12, 6, 3, & 9 placed first?	1 Yes 0 No	**E2CLX06**
7.	Is the spacing intact? (Symmetry on either side of 12 o'clock and 6 o'clock?)	1 Yes 0 No	**E2CLX07**
8.	Were only Arabic numerals used?	1 Yes 0 No	**E2CLX08**
9.	Are only the numbers 1 through 12 among the numerals present?	1 Yes 0 No	**E2CLX09**
10.	Is the sequence 1 through 12 intact? (No omissions or intrusions.)	1 Yes 0 No	**E2CLX10**
11.	Are there exactly 2 hands present? (Ignore sectoring/tic marks)	1 Yes 0 No	**E2CLX11**
12.	Are all hands represented as arrows?	1 Yes 0 No	**E2CLX12**
13.	Is the hour hand between 1 o'clock and 2 o'clock?	1 Yes 0 No	**E2CLX13**
14.	Is the minute hand obviously longer than the hour hand?	1 Yes 0 No	**E2CLX14**
15.	Are there any of the following...?		
	a) Hand pointing to 4 or 5 o'clock?	1 Yes 0 No	**E2CLX15A**
	b) "1:45" present?	1 Yes 0 No	**E2CLX15B**
	c) Any other notation (e.g. "9:00")?	1 Yes 0 No	**E2CLX15C**
	d) Any arrows point inward?	1 Yes 0 No	**E2CLX15D**
	e) Intrusions from "hand" or "face" present?	1 Yes 0 No	**E2CLX15E**
	f) Any letters, words or pictures?	1 Yes 0 No	**E2CLX15F**

HEARING TEST

1 Do you have frequent ear infections?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HINF**

In which ear?

① Right ② Left ③ Both right and left ⑧ Don't know **E2HINFLR**

2 Do you have buzzing or ringing in your ear?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HBUZ**

In which ear?

① Right ② Left ③ Both right and left ⑧ Don't know **E2HBUZLR**

3 Have you ever had ear surgery?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HSUR**

In which ear?

① Right ② Left ③ Both right and left ⑧ Don't know **E2HSURLR**

4 Do you wear a hearing aid?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HAID**

a. In what ear?

① Right ② Left ③ Both right and left **E2HAIDLR**

b. Do you wear it...?

(Examiner Note: Read response options.)

③ Most of the time ② Some of the time ① A little of the time ⑧ Don't know **E2HAIDWR**

5 Can you hear well enough (with a hearing aid if necessary) to carry on a conversation in a crowded room?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HCONV**

---

6 Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HLIMIT**

---

7 Did you ever work in a job, military service, or hobby that was so noisy or loud that you had to raise your voice to speak to someone?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **E2HJOB**

↓

Was this for a year or more?

① Yes ⓪ No ⑧ Don't know **E2HJOBYR**

Examiner Note: Check each ear for cerumen in the ear canal. Explain what you are doing to the participant:

Script: "I will be placing this instrument in both of your ears, first the right and then the left."

8 Is cerumen blocking the right ear canal?

① Yes ⓪ No ⑧ Don't know ⑦ Participant refused exam **E2HBLKR**

---

9 Is cerumen blocking the left ear canal?

① Yes ⓪ No ⑧ Don't know ⑦ Participant refused exam **E2HBLKL**

Administer test:

Script: "The object of this test is to find the faintest tones that you can hear. Different tone pitches will be heard in each ear one at a time. Some of the tones will be high pitched and some will be low pitched. Some of the tones will be very soft. Please raise your hand as soon as you hear the tones begin and lower your hand as soon as the tones stop. Raise your hand even if you hear the faintest sound and have to guess."

Air Conduction Results, Left Ear

Frequencies	Hearing Level in Decibels
1000 Hz	E2HL1000
2000 Hz	E2HL2000
4000 Hz	E2HL4000
8000 Hz	E2HL8000
250 Hz	E2HL250
500 Hz	E2HL500

Air Conduction Results, Right Ear

Frequencies	Hearing Level in Decibels
1000 Hz	E2HR1000
2000 Hz	E2HR2000
4000 Hz	E2HR4000
8000 Hz	E2HR8000
250 Hz	E2HR250
500 Hz	E2HR500

Was the audiometry test completed?

① Yes, test completed ③ No, test incomplete ⓪ No, test not done **E2HCOMP**

Why was the test incomplete or not done?

E2HINC

① Tried but unable

② Participant unable to understand instructions

⑦ Participant refused

③ Other ***(Please specify:)*** _____

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ /	
ZBID	ZBACROS	Month Day Year ZBDATE	ZBSTFID

CORE HOME VISIT WORKBOOK

Version 1.2, 1/12/00

Arrival Time: : **ZBTIME1**
Hours Minutes

Departure Time: : **ZBTIME2**
Hours Minutes

Year of annual contact: **ZBTYPE**

③ Year 03 ⑥ Year 06
④ Year 04 ⑦ Year 07
⑤ Year 05 ⑧ Other *(Please specify)*

CORE HOME VISIT PROCEDURE CHECKLIST

		Page Numbers	Please mark if done	Comments
1.	Home Visit Interview	2	1 ○ Completed interview 2 ○ Partial interview: All priority questions completed 3 ○ Partial interview: Priority questions incomplete 4 ○ Not done	ZBHV
2.	Medication Inventory Update	29	① Yes ⓪ No	ZBMI
3.	Weight	34	① Yes ⓪ No	ZBWT
4.	Radial Pulse	34	① Yes ⓪ No	ZBRP
5.	Blood Pressure	35	① Yes ⓪ No	ZBBP
6.	Grip Strength	36	① Yes ⓪ No	ZBGRIP
7.	Standing Balance	37	① Yes ⓪ No	ZBSB
8.	Chair Stands	38	① Yes ⓪ No	ZBCS
9.	4-meter Walk	40	① Yes ⓪ No	ZB4MW
10.	Knee Crepitus	41	① Yes ⓪ No	ZBKNEE
11.	Isometric Strength (Isometric Chair)	42	① Yes ⓪ No	ZBISO
12.	Ultrasound	45	① Yes ⓪ No	ZBULTRA
13.	DXA: Did participant agree to come into clinic for DXA?	47	① Yes ⓪ No ⑤ Not applicable	ZBDXA
14.	Was blood collected?		① Yes ⓪ No ⑤ Not applicable	ZBBLOOD
15.	Was urine collected?		① Yes ⓪ No ⑤ Not applicable	ZBURINE
16.	Was the Visit-specific Home Visit Workbook filled out (either in part or completely)?		① Yes ⓪ No ⑤ Not applicable	ZBHVWK
17.	Was the Substudy Workbook filled out (either in part or completely)?		① Yes ⓪ No ⑤ Not applicable	ZBSUB
18.	Did participant agree to schedule an x-ray?		① Yes ⓪ No ⑤ Not applicable ⑨ Not eligible	ZBXR

Draft

Page Link # **ZBLINK**

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
ZCID	ZCACROS	ZCDATE	ZCSTFID

CORE HOME VISIT WORKBOOK

Year of annual contact: ③ Year 03 ④ Year 04 ⑤ Year 05 ⑥ Year 06 ⑦ Year 07 ⑧ Other *(Please specify)* _____ **ZCTYPE**

Type of contact: ① Home (face-to-face interview) ② Telephone interview ③ Other *(Please specify)* _____ **ZCCONTAC**

Date of last regularly scheduled contact: ☆ = **Priority questions**

Month / Day / Year **ZCDATES**

☆ **1.** In general, how would you say your health is? Would you say it is. . .
(Interviewer Note: Read response options.)

① Excellent ② Very good ③ Good ④ Fair ⑤ Poor ⑧ Don't know ⑦ Refused **ZCHSTAT**

☆ **2.** Since we last spoke to you about 6 months ago, did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital. **ZCBED12**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

☆ About how many days did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

___ days **ZCBEDDAY**

☆ **3.** Since we last spoke to you about 6 months ago, did you cut down on the things you usually do, such as going to work or working around the house, because of an illness or injury? Please include days in bed. **ZCCUT12**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

☆ How many days did you cut down on the things you usually do because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

___ days **ZCCUTDAY**

4. Since we last spoke to you about 6 months ago, did you stay overnight as a patient in a nursing home or rehabilitation center?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCMCNH**

5. Since we last spoke to you about 6 months ago, did you receive care at home from a visiting nurse, home health aide, or nurse's aide?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCMCVN**

6. Since we last spoke to you about 6 months ago, have you had a cold or flu that was bad enough to keep you in bed for all or most of the day?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCFLU**

a. Did you take your temperature? **ZCTEMP**

① Yes ⓪ No ⑧ Don't know

Go to Question #6b

Was your temperature 100° or higher? **ZCTEMPHI**

① Yes * ⓪ No ⑧ Don't know

b. Did a doctor or nurse tell you that you had the flu or a fever? **ZCFLUDR**

① Yes ⓪ No ⑧ Don't know

c. Did you have body aches, chills, or muscle weakness that lasted two or more days? **ZCACHES**

① Yes ⓪ No ⑧ Don't know

d. Were you hospitalized overnight for pneumonia or bronchitis following the illness? **ZCPNEU**

① Yes ⓪ No ⑧ Don't know

7. Did you get a flu shot in the past 12 months? **ZCFSHOT**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

When did you get your most recent flu shot? If you are unsure, please make your best guess.

		/				

Month Year **ZCMOYR**

**** Interviewer Note: Please complete Substudy Workbook.***

8. Because of a health or physical problem, do you have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks? ***(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Don't do.")***

ZCDWQMYN

① Yes
⓪ No → Go to Question #8c
⑧ Don't know → Go to Question #8c
⑦ Refused → Go to Question #8c
⑨ Don't do → Go to Question #9

a. How much difficulty do you have? ***(Interviewer Note: Read response options.)***

ZCDWQMDF

① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it?
⑧ Don't know

b. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?

(Interviewer Note: If "some other reason," probe for response. Do NOT read response options. Mark only ONE answer.)

ZCMNRS

① Arthritis
② Back pain
③ Balance problems/unsteadiness on feet
④ Cancer
⑤ Chest pain/discomfort
⑥ Circulatory problems
⑦ Diabetes
⑧ Fatigue/tiredness (no specific disease)
⑨ Fall
⑩ Heart disease (including angina, congestive heart failure, etc)
⑪ High blood pressure/hypertension
⑫ Hip fracture
⑬ Injury (Please specify: _____)
⑭ Joint pain
⑮ Lung disease (asthma, chronic bronchitis, emphysema, etc)
⑯ Old age (no mention of a specific condition)
⑰ Osteoporosis
⑱ Shortness of breath
⑲ Stroke
⑳ Other symptom (Please specify: **ZCMNRS4**)
㉑ Multiple conditions/symptoms given; unable to determine MAIN reason
㉒ Don't know

Go to Question #9

8c. How easy is it for you to walk a quarter of a mile?
(Interviewer Note: Read response options.)

ZCDWQMEZ

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/Don't do

8d. Do you get tired when you walk a quarter of a mile?

ZCDWQMT2

① Yes
⓪ No
⑧ Don't know/Don't do

8e. Because of a health or physical problem, do you have any difficulty walking a distance of one mile, that is about 8 to 12 blocks?

ZCDW1MYN

① Yes → Go to Question #9
⓪ No → Go to Question #8f
⑧ Don't know/Don't do → Go to Question #8f

8f. How easy is it for you to walk one mile?
(Interviewer Note: Read response options.)

ZCDW1MEZ

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/Don't do

9. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting?

(Interviewer Note: If the participant responds "Don't do", probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, mark "Yes". If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, mark "Don't do".)

ZCDW10YN

(1) Yes

(0) No → Go to Question #9c

(8) Don't know → Go to Question #9c

(7) Refused → Go to Question #9c

(9) Don't do → Go to Question #10

a. How much difficulty do you have?

(Interviewer Note: Read response options.)

ZCDIF

(1) A little difficulty
(2) Some difficulty
(3) A lot of difficulty
(4) Or are you unable to do it?
(8) Don't know

b. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?

(Interviewer Note: If "some other reason," probe for response. Do NOT read response options. Mark only ONE answer.)

ZCMNRS2

(1) Arthritis
(2) Back pain
(3) Balance problems/unsteadiness on feet
(4) Cancer
(5) Chest pain/discomfort
(6) Circulatory problems
(7) Diabetes
(8) Fatigue/tiredness (no specific disease)
(9) Fall
10 ○ Heart disease (including angina, congestive heart failure, etc)
11 ○ High blood pressure/hypertension
12 ○ Hip fracture
13 ○ Injury (Please specify: _____)
14 ○ Joint pain
15 ○ Lung disease (asthma, chronic bronchitis, emphysema, etc)
16 ○ Old age (no mention of a specific condition)
17 ○ Osteoporosis
18 ○ Shortness of breath
19 ○ Stroke
20 ○ Other symptom (Please specify: _____) **ZCMNRS3**
21 ○ Multiple conditions/symptoms given; unable to determine MAIN reason
22 ○ Don't know

Go to Question #10

9c. How easy is it for you to walk up 10 steps without resting?
(Interviewer Note: Read response options.)

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/Don't do

ZCDW10EZ

9d. Do you get tired when you walk up 10 steps without resting?

① Yes
⓪ No
⑧ Don't know/Don't do

ZCDW10WX

9e. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

① Yes → Go to Question #10
⓪ No → Go to Question #9f
⑧ Don't know/Don't do → Go to Question #9f

ZCDW20YN

9f. How easy is it for you to walk up 20 steps without resting?
(Interviewer Note: Read response options.)

① Very easy
② Somewhat easy
③ Or not that easy
⑧ Don't know/Don't do

ZCDW20EZ

10. Do you have to use a cane, walker, crutches, or other special equipment to help you get around?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCEQUIP**

11. Because of a health or physical problem, do you have any difficulty getting in and out of bed or chairs?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCDIOYN**

How much difficulty do you have?
(Interviewer Note: Read response options.)

ZCDIODIF
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it?
⑧ Don't know

Do you usually receive help from another person when you get in and out of bed or chairs?

① Yes ⓪ No ⑧ Don't know

ZCDIORHY

12. Do you have any difficulty bathing or showering? **ZCBATHYN**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)

ZCBATHDF
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it?
⑧ Don't know

Do you usually receive help from another person in bathing or showering?

① Yes ⓪ No ⑧ Don't know

ZCBATHRH

13. Do you have any difficulty dressing? **ZCDDYN**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

How much difficulty do you have?
(Interviewer Note: Read response options.)

ZCDDDIF
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are you unable to do it?
⑧ Don't know

Do you usually receive help from another person in dressing?

① Yes ⓪ No ⑧ Don't know

ZCDDRHYN

14. Because of a health or physical problem, do you have any difficulty preparing meals? **ZCDFPREP**

① Yes ⓪ No ⑨ Does not do ⑧ Don't know ⑦ Refused

15. Because of a health or physical problem, do you have any difficulty shopping for food? **ZCDFSHOP**

① Yes ⓪ No ⑨ Does not do ⑧ Don't know ⑦ Refused

16. Now I am going to ask some questions about the type and amount of physical activity that you did in the past 12 months and what you usually do in a typical week.

In the past 12 months, did you walk up a flight of stairs (a flight is about 10 steps), at least 10 times?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCFS12MO**

⓪ ⑧ ⑦ → Go to Question #17

① Yes

a. In the past 7 days, did you walk up a flight of stairs? **ZCS7DAY**

① Yes ⓪ No ⑧ Don't know

⓪ → Go to Question #17

b. About how many flights did you walk up in the past 7 days? If you are unsure, please make your best guess.

ZCFSNUM

[ ][ ][ ] flights ⑨⑧ Don't know **ZCFSNUMD**

c. About how many of these flights did you walk up carrying a small load like laundry, groceries, or an infant?

[ ][ ][ ] flights ⑨⑧ Don't know **ZCFSLODK**

ZCFSLOAD

17. In the past 12 months, did you walk for exercise, or walk to work, the store, church or walk the dog, at least 10 times? **ZCEW12MO**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

⓪ ⑧ ⑦ → Go to Question #18

① Yes → In the past 7 days, did you go walking? **ZCEW7DAY**

① Yes ⓪ No

① Yes

a. How many times did you go walking in the past 7 days?

ZCEWTIME ☐☐ times

ZCEWTMDK -① Don't know

b. About how much time, on average, did you spend walking each time you walked (excluding rest periods)?

(Interviewer Note: If less than 1 hour, record number of minutes.)

ZCEWHRS ☐☐ Hours **ZCEWMINS** ☐☐ Minutes

-① Don't know **ZCEWTDK**

c. When you walk, do you usually walk at a brisk pace *(as fast as you can),* a moderate pace, or at a leisurely stroll?

① brisk
② moderate
③ stroll
⑧ Don't know

ZCEWPACE

d. About how many blocks, on average, did you walk each time?

☐☐ blocks

ZCEWBLUK -① Number of blocks unknown

ZCEWBLOX

Do you know how far you usually walk in something other than blocks, e.g., mall lengths, miles, laps around a track? **ZCEWKNOW**

① Yes ⓪ No

a. What is the unit of measure? ☐☐☐☐☐☐☐☐☐☐

ZCEWUNIT

b. How many do you walk, on average? ☐☐☐ units

-① Don't know

ZCEWNUMU **ZCEWUNDK**

No ⓪ → What is the main reason you did not go walking in the past 7 days?

① bad weather
② not enough time
③ injury
④ health problems
⑤ lost interest
⑥ felt unsafe
⑦ not necessary
⑧ other

ZCEWREAS

→ Go to Question #18

MEDICAL CONDITIONS IN PAST 12 MONTHS

18. This next question is about caregiving activities that you may do. Do you currently provide any regular care or assistance to a child or a disabled or sick adult?

(1) Yes (0) No (8) Don't know (7) Refused **ZCVWCURA**

Go to Question #19

About how many hours per week do you provide care to another person?
If you are unsure, please make your best guess.

ZCVWAHAW ___ hours (-1) Don't know **ZCVWDK**

Now I'm going to ask you about some medical problems that you might have had in the past 12 months.

In the past 12 months, has a doctor told you that you had...?

19. Hypertension or high blood pressure? We are specifically interested in hearing about hypertension or high blood pressure that was diagnosed for the first time in the past 12 months.

(1) Yes (0) No (8) Don't know (7) Refused **ZCHCHBP**

20. Diabetes or sugar diabetes? Again, we are specifically interested in hearing about diabetes that was diagnosed for the first time in the past 12 months.

(1) Yes (0) No (8) Don't know (7) Refused **ZCSGDIAB**

21. In the past 12 months, have you seen a health professional for new or worsening symptoms of...?

a. Chest pain	(1) Yes	(0) No	(8) Don't know	(7) Refused	**ZCCP**
b. Shortness of breath	(1) Yes	(0) No	(8) Don't know	(7) Refused	**ZCSOB**
c. Angina	(1) Yes	(0) No	(8) Don't know	(7) Refused	**ZCANGI**

22. In the past 12 months, have you fallen and landed on the floor or ground? **ZCAJFALL**

(1) Yes (0) No (8) Don't know (7) Refused

Please go to Question #23

How many times have you fallen in the past 12 months?
If you are unsure, please make your best guess.

ZCAJFNUM

(1) One
(2) Two or three
(4) Four or five
(6) Six or more
(8) Don't know

MEDICAL CONDITIONS IN PAST 6 MONTHS

Now I'm going to ask you about any medical problems you might have had since we last spoke to you about 6 months ago, which was on ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

23. Since we last spoke to you about 6 months ago, has a doctor told you that you had a heart attack, angina, or chest pain due to heart disease? **ZCHCHAMI**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Were you hospitalized overnight for this problem? **ZCHOSMI**

① Yes

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization.
Record reference #'s below:

ZCREF23A a. ☐☐☐☐☐

ZCREF23B b. ☐☐☐☐☐

ZCREF23C c. ☐☐☐☐☐

⓪ No → Go to Question #24

24. Since we last spoke to you about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ? **ZCHCCVA**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Were you hospitalized overnight for this problem? **ZCHOSMI2**

① Yes

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization.
Record reference #'s below:

ZCREF24A a. ☐☐☐☐☐

ZCREF24B b. ☐☐☐☐☐

ZCREF24C c. ☐☐☐☐☐

⓪ No → Go to Question #25

25. Since we last spoke to you about 6 months ago, has a doctor told you that you had congestive heart failure? **ZCCHF**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Were you hospitalized overnight for this problem? **ZCHOSMI3**

① Yes

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization.
Record reference #'s below:

ZCREF25A a. ☐☐☐☐☐

ZCREF25B b. ☐☐☐☐☐

ZCREF25C c. ☐☐☐☐☐

⓪ No → Go to Question #26

26. Since we last spoke to you about 6 months ago, has a doctor told you that you had cancer? We are specifically interested in hearing about a cancer that your doctor diagnosed for the first time since we last spoke to you.

ZCCHMGMT

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. ☐☐☐☐☐ **ZCREF26A**

b. ☐☐☐☐☐ **ZCREF26B**

c. ☐☐☐☐☐ **ZCREF26C**

27. Since we last spoke to you about 6 months ago, has a doctor told you that you had pneumonia?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCLCPNEU**

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. ☐☐☐☐☐ **ZCREF27A**

b. ☐☐☐☐☐ **ZCREF27B**

c. ☐☐☐☐☐ **ZCREF27C**

28. Since we last spoke to you about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

ZCOSBR45

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. ☐☐☐☐☐ **ZCREF28A**

b. ☐☐☐☐☐ **ZCREF28B**

c. ☐☐☐☐☐ **ZCREF28C**

29. Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCHOSP12**

Complete a Health ABC Event Form(s), Section I, for each event. Record reference #'s and reason for hospitalization below.

a. ☐☐☐☐☐ Reason for hospitalization: **ZCREF29A**

b. ☐☐☐☐☐ Reason for hospitalization: **ZCREF29B**

c. ☐☐☐☐☐ Reason for hospitalization: **ZCREF29C**

d. ☐☐☐☐☐ Reason for hospitalization: **ZCREF29D**

e. ☐☐☐☐☐ Reason for hospitalization: **ZCREF29E**

f. ☐☐☐☐☐ Reason for hospitalization: **ZCREF29F**

30. Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZCOUTPA**

Was it for. . .?

Reference #'s

a. A procedure to open a blocked artery **ZCBLART** — ① Yes ⓪ No ⑧ Don't know → ***Complete a Health ABC Event form, Section III. Record reference #:*** ☐☐☐☐☐ **ZCREF30A**

b. Gall bladder surgery **ZCGALLBL** — ① Yes ⓪ No ⑧ Don't know

c. Cataract surgery **ZCCATAR** — ① Yes ⓪ No ⑧ Don't know

d. Hernia repair (Inguinal abdominal hernia.) **ZCHERN** — ① Yes ⓪ No ⑧ Don't know

e. TURP (MEN ONLY) (transurethral resection of prostate) **ZCTURP** — ① Yes ⓪ No ⑧ Don't know

f. Other **ZCOTH** — ① Yes → ⓪ No ⑧ Don't know

Please specify the type of outpatient surgery.

i. _____

ii. _____

iii. _____

31. Is there any other illness or condition for which you see a doctor or other health care professional?

① Yes ⓪ No ⑧ Don't know ⑦ Refused

ZCOTILL

Please go to Question #32

Please describe for what:

_____

_____

_____

_____

32. This next question refers to the <u>past month</u>. In the past month, on the average, have you been feeling unusually tired during the day?

ZCELTIRE

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Have you been feeling unusually tired...?

(Interviewer Note: Read response options.)

① All of the time
② Most of the time
③ Some of the time
⑧ Don't know
⑦ Refused

ZCELOFTN

Now I am going to ask you some questions about pain, aching or stiffness in, or around your knee. This includes the front, back and sides of the knee.

33. In the past 12 months, have you had any pain, aching or stiffness in either knee? **ZCAJK12**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Go to Question #34

In the past 12 months, have you had pain, aching or stiffness in either knee on most days for at least one month? **ZCAJKMD**

① Yes * ⓪ No ⑧ Don't know

Have you had this pain in your right knee, left knee, or both knees?
(Interviewer Note: Mark only one answer.)

① Right knee only
② Left knee only
③ Both right and left knee
⑧ Don't know

ZCAJLRB1

34. Now, please think about the past 30 days. In the past 30 days, have you had any pain, aching or stiffness in either knee? **ZCAJK30**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Go to Question #35.

a. In the past 30 days, have you had pain, aching or stiffness in either knee on most days?

① Yes * ⓪ No ⑧ Don't know **ZCAJKMS**

b. In the past 30 days, how much pain have you had in your knees for each activity I will describe. How much pain have you had while...? ***(Interviewer Note: Read each activity separately. Read response options.)***

	None	Mild	Moderate *	Severe *	Extreme *	Don't know	
a) Walking on a flat surface	⓪	①	②	③	④	⑧	ZCAJKFS
b) Going up or down stairs	⓪	①	②	③	④	⑧	ZCAJKST
c) At night while in bed	⓪	①	②	③	④	⑧	ZCAJKBD
d) Standing upright	⓪	①	②	③	④	⑧	ZCAJKUP
e) Getting in or out of a chair	⓪	①	②	③	④	⑧	ZCAJKCH
f) Getting in or out of a car	⓪	①	②	③	④	⑧	ZCAJKIN

c. Have you had this pain in your right knee, left knee, or both knees?
(Interviewer Note: Mark only one answer.) **ZCAJLRB2**

① Right knee only ② Left knee only ③ Both right and left knee ⑧ Don't know

* ***Interviewer Note: Participant may be eligible for knee x-ray. If knee x-rays are a part of this year's exam, go to Home Visit Knee X-ray Tracking Form.***

35. In general, would you say that your appetite or desire to eat has been. . . ?
(Interviewer Note: Read response options.) **ZCAPPET**

① Very good
② Good
③ Moderate
④ Poor
⑤ Very poor
⑧ Don't know
⑦ Refused

36. How much do you currently weigh?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

☐☐☐ pounds **ZCWTLBS**

⑧ Don't know/don't remember ⑦ Refused **ZCLBS2**

37. Since we last spoke to you about 6 months ago, has your weight changed by 5 or more pounds?

① Yes ⓪ No ⑧ Don't know ⑦ Refused
ZCCHN5LB

a. Did you gain or lose weight?

① Gain ② Lose ⑧ Don't know/don't remember **ZCGNLS**

b. How many pounds did you gain/lose in the past 6 months?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

☐☐ pounds **ZCHOW6**

⑧ Don't know/don't remember **ZCHOW6DN** ⑦ Refused

c. Were you trying to gain/lose weight?

① Yes ⓪ No ⑧ Don't know
ZCTRGNLS

38. At the present time, are you trying to lose weight? **ZCTRYLOS**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

39. Now I have some questions about your feelings during the past week. For each of the following statements, please tell me if you felt that way: Rarely or None of the time; Some of the time; Much of the time; Most or All of the time. ***(Interviewer Note: REQUIRED - Show card #1.)***

	Rarely or None of the time (<1 day)	Some of the time (1-2 days)	Much of the time (3-4 days)	Most or All of the time	Don't know	Refused
a. I was bothered by things that usually don't bother me. **ZCFBOTHR**	①	②	③	④	⑧	⑦
b. I did not feel like eating: my appetite was poor. **ZCFEAT**	①	②	③	④	⑧	⑦
c. I felt that I could not shake off the blues even with help from my family and friends. **ZCFBLUES**	①	②	③	④	⑧	⑦
d. I felt that I was just as good as other people. **ZCFGOOD**	①	②	③	④	⑧	⑦
e. I had trouble keeping my mind on what I was doing. **ZCFMIND**	①	②	③	④	⑧	⑦
f. I was depressed. **ZCFDOWN**	①	②	③	④	⑧	⑦
g. I felt that everything I did was an effort. **ZCFEFFRT**	①	②	③	④	⑧	⑦
h. I felt hopeful about the future. **ZCFHOPE**	①	②	③	④	⑧	⑦
i. I thought my life had been a failure. **ZCFFAIL**	①	②	③	④	⑧	⑦
j. I felt fearful. **ZCFFEAR**	①	②	③	④	⑧	⑦
k. My sleep was restless. **ZCFSLEEP**	①	②	③	④	⑧	⑦
l. I was happy. **ZCFHAPPY**	①	②	③	④	⑧	⑦
m. It seemed that I talked less than usual. **ZCFTALK**	①	②	③	④	⑧	⑦
n. I felt lonely. **ZCFLONE**	①	②	③	④	⑧	⑦
o. People were unfriendly. **ZCFUNFR**	①	②	③	④	⑧	⑦
p. I enjoyed life. **ZCFENJOY**	①	②	③	④	⑧	⑦
q. I had crying spells. **ZCFCRY**	①	②	③	④	⑧	⑦
r. I felt sad. **ZCFSAD**	①	②	③	④	⑧	⑦
s. I felt that people disliked me. **ZCFDISME**	①	②	③	④	⑧	⑦
t. I could not get going. **ZCFNOGO**	①	②	③	④	⑧	⑦

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ /	
ZDID	ZDACROS	Month Day Year ZDDATE	ZDSTFID

CORE HOME VISIT WORKBOOK
LIFE EVENTS

Year of annual contact: **ZDTYPE**

③ Year 03 ⑥ Year 06

④ Year 04 ⑦ Year 07

⑤ Year 05 ⑧ Other ***(Please specify)***

40. Did your spouse or partner die in the past 12 months? **ZDLESDIE**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

41. Did a child, grandchild, close friend, or relative die in the past 12 months? **ZDLERDIE**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

42. Has a close friend or family member had a serious accident or illness in the past 12 months?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **ZDLEACC**

ZDLINK

Page Link #

Version 1.2, 01/12/2000 pjm

Draft

43. Have you changed your doctor or place that you usually go for health care or advice about your health care in the past 12 months?

① Yes ⓪ No ② I don't have a doctor or place that I usually go for health care ⑧ Don't know ⑦ Refused

ZDHCADV

Interviewer Note:
- ***If Year 3, go to Questions #43a and #43b.***
- ***If Year 4-7, go to Question #44.***

a. Where do you usually go for health care or advice about health care?
(Interviewer Note: Read response options. Please mark only one.)

ZDHCSRC

① Private doctor's office (individual or group practice)

② Public clinic such as a neighborhood health center

③ Health Maintenance Organization (HMO) ***(Please specify:_____)***
(Examples: Security Blue, US Healthcare, Health America, The Apple Plan, Omnicare, Prucare)

④ Hospital outpatient clinic

⑤ Emergency room

⑥ Other ***(Please specify:*** _____ ***)***

b. Please tell me the name, address, and telephone number of the doctor or place that you usually go to for health care.

ZDDFNAME
First Name

ZDDLNAME
Last Name

ZDDSTRT
Street Address

ZDDCITY
City

State

ZDDSTATE

ZDDZIP
Zip Code

Telephone: ( ) - **ZDDPHONE**
Area Code Number

44. We would like to update all of your contact information this year. The address that we currently have listed for you is ***(Interviewer Note: Please read address from the Data from Prior Visits Report):***

Please tell me if the information I have is still correct.

(Interviewer Note: If Year 3, clearly record correct address FOR ALL PARTICIPANTS below, even if contact information has not changed from previous years. If Year 4-Year 7, record address only if it needs to be corrected and/or updated.)

ZDFNAME
First Name

ZDLNAME
Last Name

ZDSTREET
Street Address

ZDAPT
Apt/Room

ZDSTATE

ZDCITY
City

State

( ) - **ZDZIP**
Zip Code

The telephone number(s) that we currently have for you is (are)
(Interviewer Note: Please read telephone number(s) from the Data from Prior Visits Report):

Please tell me if this telephone number is correct.

(Interviewer Note: If Year 3, clearly record correct telephone number(s) FOR ALL PARTICIPANTS below, even if contact information has not changed from previous years. If Year 4-Year 7, record telephone number (s) only if they need to be corrected and/or updated.)

Home Telephone #: ( ) - **ZDPHONE**
Area Code Number

Work Telephone #: ( ) - **ZDWKPHON**
Area Code Number

45. Do you expect to move or have a different mailing address in the next 6 months?

Yes ① No ⓪ Don't know ⑧ Refused ⑦ **ZDMOVE**

a. Do you know what your new mailing address will be?

Yes ① No ⓪ **ZDMOVE2**

What will be your new mailing address?

New address:

ZDMASTRT
Street Address

ZDMAAPT
Apt/Room

ZDMACITY
City

State **ZDMASTAT**

ZDMAZIP
Zip Code

① Permanent address
② Winter address
④ Summer address
③ Other *(Please describe:* **ZDADDRES** _____ *)*

Telephone:

( ) - **ZDMATELE**
Area Code Number

Date new address/phone number effective:

/ / **ZDMADATE**
Month Day Year

46. You previously told us the name of someone who could provide information and answer questions for you in the event that you were unable to answer for yourself. Please tell me if the information I have is still correct.

(Interviewer Note: Refer participant's chart. Ideally, this contact should be a relative who lives with the participant. If Year 3, clearly record contact information for all participants, even if contact information has not changed from previous years. If Year 4-Year 7, record contact information only if it needs to be corrected and/or updated.)

a.

ZDCIFNAM
First Name

ZDCILNAM
Last Name

ZDCISTRT
Street Address

ZDCIAPT
Apt/Room

ZDCICITY
City

ZDCISTAT
State

ZDCIZIP
Zip Code

Telephone:

( ) - **ZDCITELE**
Area Code Number

b. How is this person related to you?

① My husband or wife
② My son or daughter
③ My niece or nephew
④ My grandchild
⑤ My brother or sister
⑥ My mother or father
⑦ Friend/neighbor
⑧ Someone else ***(Pleasesayhowrelated:)***

ZDCIREL

c. Is this person your next of kin?

① Yes ⓪ No ⑧ Don't know ⑦ Refused

ZDCINOK

d. Have you given this person power of attorney?

① Yes ⓪ No ⑧ Don't know ⑦ Refused

ZDCIPOA

47. You previously told us the name, address, and telephone number of two close friends or relatives who do not live with you and who would know how to reach you in case you move and we need to get in touch with you. These people did not have to be local people. Please tell me if the information I have is still correct.

(Interviewer Note: Refer to participant's chart. If Year 3, clearly record contact information for all participants, even if contact information has not changed from previous years. If Year 4- Year 7, record contact information only if it needs to be corrected and/or updated. Ideally, these contacts should not live with the participant.)

Contact #1

a.

ZDC1FNAM
First Name

ZDC1LNAM
Last Name

ZDC1STRT
Street Address

ZDC1APT
Apt/Room

ZDC1CITY
City

State **ZDC1STAT**

ZDC1ZIP -
Zip Code

Telephone:

( ) - **ZDC1PHON**
Area Code Number

b. How is this person related to you?

① My son or daughter
② My niece or nephew
③ My grandchild
④ My brother or sister
⑤ My mother or father
⑥ Friend/neighbor
⑦ Someone else *(Please say how related:)* **ZDC1REL**

c. Is this person your next of kin? **ZDC1NOK**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

d. Have you given this person power of attorney? **ZDC1POA**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

47a.

Contact #2

a. ZDC2FNAM
First Name

ZDC2LNAM
Last Name

ZDC2STRT
Street Address

Apt/Room ZDC2APT

ZDC2CITY
City

State ZDC2STAT

ZDC2ZIP -
Zip Code

Telephone:

( ) - ZDC2PHON
Area Code Number

b. How is this person related to you?

① My son or daughter
② My niece or nephew
③ My grandchild
④ My brother or sister
⑤ My mother or father
⑥ Friend/neighbor
⑦ Someone else *(Please say how related:)* ZDC2REL

c. Is this person your next of kin? ZDC2NOK

① Yes ⓪ No ⑧ Don't know ⑦ Refused

d. Have you given this person power of attorney? ZDC2POA

① Yes ⓪ No ⑧ Don't know ⑦ Refused

48. Has the participant previously identified their next of kin in Question #46, #47 or #47a?

① Yes ⓪ No **ZDKNOK**

Who is your next of kin?

ZDKFNAME
First Name

ZDKLNAME
Last Name

ZDKSTRT
Street Address

ZDKAPT
Apt/Room

ZDKCITY
City

ZDKSTATE
State

- **ZDKZIP**
Zip Code

Telephone:

( ) - **ZDKPHONE**
Area Code Number

How is this person related to you?

① My husband or wife
② My son or daughter
③ My niece or nephew
④ My grandchild
⑤ My brother or sister
⑥ My mother or father
⑦ Friend/neighbor
⑧ Someone else *(Please say how related:)* **ZDKREL**

49. Has the participant previously identified their power of attorney in Question #46, #47 or #47a?

① Yes ⓪ No **ZDPPOA**

Have you given anyone power of attorney?

① Yes ⓪ No **ZDPAYN**

ZDPAFNAM
First Name

ZDPALNAM
Last Name

ZDPASTRT
Street Address

ZDPAAPT
Apt/Room

ZDPACITY
City

State **ZDPASTAT**

ZDPAZIP
Zip Code

Telephone:

( ) - **ZDPAPHON**
Area Code Number

How is this person related to you?

① My husband or wife
② My son or daughter
③ My niece or nephew
④ My grandchild
⑤ My brother or sister
⑥ My mother or father
⑦ Friend/neighbor
⑧ Someone else *(Please say how related:)*

ZDPAREL

50. ***Interviewer Note: Please answer the following question based on your judgement of the participant's responses to the Home Visit Interview.***

On the whole, how reliable do you think the participant's responses to the Home Visit Interview are?

ZDRELY

① Very reliable

② Fairly reliable

③ Not very reliable

⑧ Don't know

51. What is the primary reason an alternate type of contact was done for the Annual Clinic Visit? Please mark only one reason.

ZDREASON

① Illness/health problem(s)

② Hearing difficulties

③ Cognitive difficulties

④ In nursing home/long-term care facility

⑤ Too busy; time and/or work conflict

⑥ Caregiving responsibilities

⑦ Physician's advice

⑧ Family member's advice

⑨ Clinic too far/travel time

10 ◯ Moved out of area

11 ◯ Travelling/on vacation

12 ◯ Personal problem(s)

13 ◯ Refused to give reason

14 ◯ Other ***(Please specify:*** _____ ***)***

Thank you very much for answering these questions. I enjoyed talking with you. Please remember to call us if you are admitted to a hospital or nursing home for any reason so that we can better understand changes in your health. We would also like to hear from you if you move or if your mailing address changes. We will be calling you in about 6 months from now to find out how you've been doing.

Interviewer Note:
If participant reported having a cold or flu in the past 6 months that was bad enough to keep them in bed for all or most of the day AND they had a temperature of 100° or higher, complete Substudy Workbook.

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
MAID/MIFIF	MAACROS	MIFDATE/MADATE	MASTAFF

HOME VISIT MEDICATION INVENTORY FORM -- page a

SectionA MedicationReception

Refer to *Data From Prior Visits* Report. Ask the participant if they have used each prescription and over-the-counter medication listed on *Data From Prior Visits Report* within the past 2 weeks. Record on the *Home Visit Medication Inventory Form* all prescription and over-the-counter medications (including pills, dermal patches, eye drops, creams, salves, and injections) used in the previous two weeks, even if already listed on the *Data From Prior Visits* Report. If possible, record the complete drug name exactly as written on the container label. Confirm strength, units, number used, etc.

We are interested in all the prescription and over-the-counter medications that you took during the past 2 weeks. We are also interested in drugs not usually prescribed by a doctor, such as supplements, vitamins, pain medications, laxatives or bowel medicines, cold and cough medications, antacids or stomach medicines, and ointments or salves.

Did the participant take any prescription or non-prescription medications in the past 2 weeks?

MAMEDS [1] Yes [0] No [8] Don't know [7] Refused

Section B Prescription Medication.

Copy the name of the prescription, the strength in milligrams (mg) or other units, the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M	1 Y 0 N MIFPRN	1 Y 0 N MIFSEEN
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR	Formulation Code: MIFFORM	X Rx 1 MIFRX / 0 Non Rx
2.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx / Non Rx
3.	MIFNAME			____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx / Non Rx
4.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx / Non Rx
5.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx / Non Rx

Page Link #

Annotated 10/15/2001 pjm
Version 1.2, 01/12/2000

SectionB Prescription Medication -- Continued

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
6.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M	1 Y 0 N MIFPRN	1 Y 0 N MIFSEEN; X Rx 1 MIFRX; 0 Non Rx
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR	Formulation Code: MIFFORM	
7.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
8.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
9.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
10.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
11.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
12.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx

☐ Continued on MIF Supplement

Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Health ABC HOME VISIT MEDICATION INVENTORY FORM--page c

Section C Over-the-counter Medications and Supplements

Copy the name of the over-the-counter medicine, the strength in milligrams (mg) or other units, the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M	1 Y 0 N MIFPRN	1 Y 0 N MIFSEEN
	Reason for use: MIFREAS			Date Started: Month MIFMONTH / Year MIFYEAR	Formulation Code: MIFFORM	Rx 1 MIFRX / X 0 Non Rx
2.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
3.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
4.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
5.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
6.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
7.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx

Health ABC HOME VISIT MEDICATION INVENTORY FORM--page d

Section C Over-the-counter Medications and Supplements (continued)

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
8.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M	1 Y 0 N MIFPRN	1 Y 0 N MIFSEEN
	Reason for use: MIFREAS			Date Started: Month MIFMONTH / Year MIFYEAR	Formulation Code: MIFFORM	Rx 1 / X Non Rx 0 MIFRX
9.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
10.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
11.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
12.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
13.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx
14.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx / X Non Rx

☐ Continued on MIF Supplement

Formulation Codes

0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
MAID/MIFIF	MAACROS	MIFDATE/MADATE	MASTAFF

HOME VISIT MEDICATION INVENTORY FORM SUPPLEMENT

Prescription and Over-the-counter Medications and Supplements

Copy the name of the prescription or over-the-counter medicine, the strength in milligrams (mg) or other units and the total number of doses taken per day, week or month.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1S.	MIFNAME	MIF STREN	MIF UNIT	MIFDWM ____ D W M	1 Y 0 N MIFPRN	1 Y 0 N MIFSEEN
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR	Formulation Code: MIFFORM	1 Rx 0 Non Rx MIFRX
2S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx Non Rx
3S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx Non Rx
4S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx Non Rx
5S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx Non Rx
6S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx Non Rx
7S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: Month / Year	Formulation Code:	Rx Non Rx

Page Link #

Version 1.2, 01/12/2000

HABC Enrollment ID # H Z4ID | Acrostic Z4ACROS

CORE HOME VISIT WORKBOOK

Year of annual contact: ③ Year 03 ④ Year 04 ⑤ Year 05 ⑥ Year 06 ⑦ Year 07 ⑧ Other *(Pleasespecify* _____ **Z4TYPE**

WEIGHT AND RADIAL PULSE

WEIGHT

□□□.□ lbs **Z4WTLBS**

Staff ID# □□□ **Z4STFID1**

RADIAL PULSE

Staff ID# □□□ **Z4STFID2**

Measurement 1 □□□ beats per 30 seconds **Z4PLSSM1** x 2 = □□□ beats per minute **Z4PULSE**

Measurement 2 □□□ beats per 30 seconds **Z4PLSMS2** x 2 = □□□ beats per minute **Z4PULSE2**

Total (Measurement 1 + Measurement 2) □□□ **Z4PLSTOT**

÷ 2

= □□□ Average beats per minute **Z4PLSAV**

CORE HOME VISIT WORKBOOK

BLOOD PRESSURE

1 **Cuff Size** ④ Small ① Regular ② Large ③ Thigh **Z4OCUF**

2 **Arm Used** ① Right ② Left → ***Please explain why right arm was not used:*** **Z4ARMRL**

(Examiner Note: Refer to Health ABC Data from Prior Visits Report.)

Pulse Obliteration Level

3 **Palpated Systolic** ___ **Z4POPS** mmHg * ***Add +30 to Palpated Systolic to obtain Maximal Inflation Level.***

Add 30*

4 **Maximal Inflation Level (MIL)** ___ † **Z4POMX** mmHg † ***If MIL is ≥ 300 mmHg, repeat the MIL. If MIL is still ≥ 300 mmHg, terminate blood pressure measurements.***

5 Was blood pressure measurement terminated because MIL ≥ 300 mmHg after second reading?

① Yes ⓪ No **Z4BPYN**

Sitting Blood Pressure Measurement #1

Comments (required for missing or unusual values):

6 **Systolic** ___ mmHg **Z4SYS**

7 **Diastolic** ___ mmHg **Z4DIA**

Sitting Blood Pressure Measurement #2

Comments (required for missing or unusual values):

8 **Systolic** ___ mmHg **Z4SY2**

9 **Diastolic** ___ mmHg **Z4DIA2**

CORE HOME VISIT WORKBOOK
GRIPSTRENGTH (Hand-Held Dynamometry)

Exclusion Criteria:

1. Has any pain or arthritis in your hands gotten worse recently? (1) Yes (0) No **Z4ARWRS**

   → Which hand? **Z4HANDRL**
   (1) Right → Do not test right.
   (2) Left → Do not test left.
   (3) Both right and left → Do not test either hand.

2. Have you had any surgery on your hands or wrists in the past three months? (1) Yes (0) No **Z4WRST1**

   → Which hand? **Z4WRTRL**
   (1) Right → Do not test right.
   (2) Left → Do not test left.
   (3) Both right and left → Do not test either hand.

Script: "I'd like you to take your right/left arm, rest it on the table, and bend your elbow. Grip the two bars in your hand, like this. You need to slowly squeeze the bars as hard as you can."

Hand the dynamometer to the participant. Adjust if needed.

Script: "Now try it once just to get the feel of it. For this practice, just squeeze gently. It won't feel like the bars are moving, but your strength will be recorded. Are the bars the right distance apart for a comfortable grip?"

Show dial to participant.

Script: "We'll do this two times. This time it counts, so when I say squeeze, squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Right (-1) Unable to test/exclusion **Z4NOTST**

Z4RTR1 Trial 1 ☐☐ kg (-1) Refused **Z4RF1** ***(Examiner Note: Wait 15-20 seconds before second trial.)***

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Z4RTR2 Trial 2 ☐☐ kg (-1) Refused **Z4RF2**

Repeat the procedure on the left side.

Script: "Now we'll test your left side. When I say squeeze, squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Left (-1) Unable to test/exclusion **Z4LNTST**

Z4LTR1 Trial 1 ☐☐ kg (-1) Refused **Z4LRF1** ***(Examiner Note: Wait 15-20 seconds before second trial.)***

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Z4LTR2 Trial 2 ☐☐ kg (-1) Refused **Z4LRF2**

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

CORE HOME VISIT WORKBOOK
STANDING BALANCE

Z4STFID5

INTRODUCTION: "I'm going to ask you to stand in several different positions that test your balance. I'll demonstrate each position and then ask you to try to stand in each position for 30 seconds. I'll be near you to provide support, and the wall is close enough to prevent you from falling if you lose your balance. Do you have any questions?"

SEMI-TANDEM STAND

Describe: "First I would like you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 30 seconds. Please watch while I demonstrate."

Demonstrate and say: "You may put either foot in front, whichever is more comfortable. You can use your arms and body to maintain your balance. Try to hold your feet in position until I say stop. If you lose your balance, take a step like this."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Examiner Note: Start timing when the participant lets go. If the participant does not hold onto your arm, start timing when they are in position. Optional script: "Ready, begin."

Z4STS

⑦ Participant refused → Go to Chair Stands.

⑨ Not attempted, unable → Go to Chair Stands.

(Please comment: _____)

① Unable to attain position or cannot hold for at least one second → STOP Semi-Tandem Stand. Go to Chair Stands.

② Holds position between 1 and 29 seconds → ___.___ **Z4STSTM** seconds. Go to Tandem Stand.

③ Holds position for 30 seconds → Go to Tandem Stand.

TANDEM STAND

Describe: "Now I would like you to try to stand with the heel of one foot in front of and touching the toes of the other foot. I'll demonstrate.

Demonstrate and say: "Again, you may use your arms and body to maintain your balance. Try to hold your feet in position until I say stop. If you lose your balance, take a step, like this."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Trial 1:

Z4TS1

⑦ Participant refused → Go to One-Leg Stand.

⑨ Not attempted, unable → Go to One-Leg Stand.

(Please comment: _____)

① Unable to attain position or cannot hold for at least one second → Go to Trial 2.

② Holds position between 1 and 29 seconds → ___.___ **Z4TSTM** seconds. Go to Trial 2.

③ Holds position for 30 seconds → Go to One-Leg Stand.

TANDEM STAND

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2: **Z4TS2**

⑦ Participant refused → Go to One-Leg Stand.

⑨ Not attempted, unable → Go to One-Leg Stand.

(Please comment: _____)

① Unable to attain position or cannot hold for at least one second → Go to One-Leg Stand.

② Holds position between 1 and 29 seconds → [ ][ ].[ ][ ] **Z4TS2TM** seconds. Go to One-Leg Stand.

③ Holds position for 30 seconds → Go to One-Leg Stand.

ONE-LEG STAND

Describe: "For the last position, I would like you to try to stand on one leg for 30 seconds. You may stand on either leg, whichever is more comfortable. I'll demonstrate."

Demonstrate and say: "Try to hold your foot up until I say stop. If you lose your balance put your foot down."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Trial 1: **Z4TR1**

⑦ Participant refused → Go to Chair Stands.

⑨ Not attempted, unable → Go to Chair Stands.

(Please comment: _____)

① Unable to attain position or cannot hold for at least one second → Go to Trial 2.

② Holds position between 1 and 29 seconds → [ ][ ].[ ][ ] **Z4TR1TM** seconds. Go to Trial 2.

③ Holds position for 30 seconds → Go to Chair Stands.

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2: **Z4TR2**

⑦ Participant refused → Go to Chair Stands.

⑨ Not attempted, unable → Go to Chair Stands.

(Please comment: _____)

① Unable to attain position or cannot hold for at least one second → Go to Chair Stands.

② Holds position between 1 and 29 seconds → [ ][ ].[ ][ ] **Z4TR2TM** seconds. Go to Chair Stands.

③ Holds position for 30 seconds → Go to Chair Stands.

CORE HOME VISIT WORKBOOK
CHAIR STANDS

SINGLE CHAIR STAND

Describe: "This is a test of strength in your legs in which you stand up from sitting without using your arms."

Demonstrate and say: "Fold your arms across your chest, like this, and stand when I say GO, keeping your arms in this position. OK?

"Test: "Ready, Go!"

Z4SCS

⑦ Participant refused	Go to 4-meter walk.
⑨ Not attempted, unable *(Please comment: _____)*	Go to 4-meter walk.
⓪ Unable to stand	Go to 4-meter walk.
① Rises using arms	Go to 4-meter walk.
② Stands without using arms	Go to Repeated Chair Stands.
③ No suitable chair	Go to 4-meter walk.

REPEATED CHAIR STANDS

Describe: "This time, I want you to stand up five times **as quickly as you can** keeping your arms folded across your chest."

Demonstrate and say: "When you stand up, come to a full standing position each time, and when you sit down, sit all the way down each time. I will demonstrate two chair stands to show you how it is done.

"Examiner Note: Rise two times as quickly as you can, counting as you sit down each time.

Test: "When I say 'Go' stand five times in a row, **as quickly as you can**, without stopping. Stand up all the way, and sit all the way down each time.

"Ready, Go!"

Examiner Note: Start timing as soon as the examiner says "Go." Count: "1, 2, 3, 4, 5" as the participant sits down each time.

Z4RCS

⑦ Participant refused

⑨ Not attempted, unable *(Please comment: _____)*

① Attempted, unable to complete 5 stands → Z4COMP Number completed

② Completes 5 stands → Z4SEC Seconds to complete

Unusual values? ① Yes ⓪ No Z4UN

Comments: _____

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

CORE HOME VISIT WORKBOOK
4-METERWALK

Z4STFID7

Examiner Note: Measure out 4 meters for the walk. If a 4-meter space is not available, measure 3 meters.

❶ Which walk was set up? **Z44MW**

① 4-meter ② 3-meter ⓪ None: No 3-meter space was available → Go to Ultrasound.

USUAL PACE WALK

❷ *Describe the 4-meter walk and demonstrate how to walk past the tape.*

Script: "This is a three part walking test. The first and second parts test your usual walking speed. Please walk past the tape, then stop. Now, wait until I say 'Go'. For the first part of this test, I want you to walk at your usual walking pace. Any questions?"

❸ *To start the test, say,*

Script: "Ready, Go."

❹ *Start timing with the first footfall over the start line (participant's foot touches the floor). Stop timing with the participant's first footfall over the finish line at 4-meters (or 3-meters). You will need to walk a few steps behind the participant. Start timing with the first footfall over the starting line (participant's foot touches the floor.)*

Z44MWTM1

Time on stopwatch: ___ . ___ (Second . Hundredths/Sec)

→ ***Examiner Note: If greater than 30 seconds mark as "Attempted, but unable to complete." Do not record time. Explain in comment section.***

⑦ Participant refused → Go to Ultrasound.

Z44MW1

⑨ Not attempted, unable → Go to Ultrasound.

(Please comment: _____)

① Attempted, but unable to complete → Go to Ultrasound.

(Please comment: _____)

❺ *Reset the stopwatch and have the participant repeat the usual-pace walk.*

Script: "For the next part of the test, I want you to walk again at your usual walking pace. When you walk past the tape please stop. Ready, Go."

Time on stopwatch: ___ . ___ **Z44MWTM2**

Second . Hundredths/Sec

❻ **RAPID WALK**

Reset the stopwatch and instruct the participant to walk as quickly as they can for the third portion of the test.

Script: "When I say go, I want you to walk as fast as you can. Ready, Go."

Time on stopwatch: ___ . ___ **Z44MWTM3**

Second . Hundredths/Sec

⑦ Participant refused → Go to Ultrasound.

Z44MW3

⑨ Not attempted, unable → Go to Ultrasound.

(Please comment: _____)

① Attempted, but unable to complete → Go to Ultrasound.

(Please comment: _____)

❼ Was the participant using a walking aid, such as a cane or walker?

① Yes ⓪ No **Z4WLKAID**

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Page Link # ____

Version 1.1, 10/26/99

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

Z4STFID8

KNEE CREPITUS

Examiner Note: If participant has an artificial leg or total knee replacement, do not test for knee crepitus on that side. Crepitus is defined as palpable continuous noise or grinding sensation (series of small clicks, pops, or grinding similar to sandpaper scratching sensation). Place your palm over the participant's patella. Ask the participant to actively move their leg to a full extended position (zero degrees) twice, then rest a moment, then twice more.

1 Have you had a knee replacement in your right knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **Z4KNREP**

→ Do not examine right knee.
Go to Question #3. Do not schedule for MRI exam.

2 Is there crepitus in the right knee?

⓪ Absent on all trials **Z4AJCRPR**
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain →
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason (e.g. artificial leg)

Concensus with 2nd examiner

⓪ Absent on all trials **Z4RN2EX**
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason

Z42EXID1
2nd examiner Staff ID#: | | | |

3 Have you had a knee replacement in your left knee?

① Yes ⓪ No ⑧ Don't know ⑦ Refused **Z4KNREPL**

→ Do not examine left knee. Do not schedule for MRI exam.

4 Is there crepitus in the left knee?

⓪ Absent on all trials **Z4AJCRPL**
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain →
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason (e.g. artificial leg)

Concensus with 2nd examiner

⓪ Absent on all trials **Z4LN2EX**
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason

Z42EXID2
2nd examiner Staff ID#: | | | |

Examiner Note: If the participant cannot fully extend their leg, assist them by holding the leg at the ankle and pumping through a full range of motion.

❶ Have you ever had knee surgery on either leg where all or part of the joint was replaced? **Z4KNRP2**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

Which leg?

① Right leg → Do NOT test right leg.

② Left leg → Do NOT test left leg.

③ Both legs **Z4KRLB3** → Do NOT test either leg. Go to Question #10.

❷ Has the participant ever had the isometric chair measurement?
(ExaminerNote:RefertotheHealthABCDatafromPriorVisitsReport.)

① Yes

Which leg was tested during the most recent isometric chair measurement?
(ExaminerNote:RefertotheHealthABCDatafromPriorVisitsReport.)
Z4ISOLEG

① Right leg → Test right leg unless contraindicated.

② Left leg → Test left leg unless contraindicated.

⓪ No **Z4ISO**

Has the participant ever had the Kin-Com exam?

① Yes **Z4KC**

Which leg was tested during the most recent Kin- Com exam? ***(ExaminerNote:RefertotheHealthABCDatafromPriorVisitsReport.)***

① Right leg → Test right leg unless contraindicated.

② Left leg → Test left leg unless contraindicated.

Z4KCLEG

⓪ No → Test right leg unless contraindicated.

ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

3 What is the seat height?

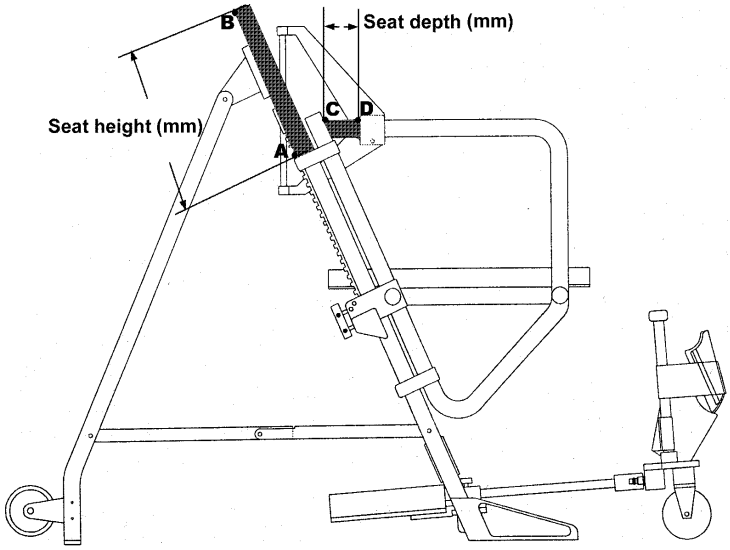
(Examiner Note: Record the seat height by measuring the distance between point "A" and "B" as noted below. Use a ruler marked in millimeters.)

[ ][ ][ ] mm **Z4SEATHT**

4 What is the seat depth?

(Examiner Note: Record the seat depth by measuring the distance between point "C" and "D" as noted below. Use a ruler marked in millimeters. Be sure that the depth is exactly the same measurement on both sides of the chair.)

[ ][ ][ ] mm **Z4SEATDP**



5 What is the length of the lower leg to be tested? [ ].[ ][ ] meters **Z4LEG1**

6 Which leg was tested?

① Right leg ② Left leg ③ Test not performed → Go to Question #10. **Z4RL4**

Trial	Maximum Torque (Nm)	Max Rate Torque (Nm/sec)	Reaction Time (msec)	Time to 50% MVTD (msec)	Did participant have knee pain?
1.	[ ][ ][ ].[ ] **Z4MT1A**	[ ][ ][ ][ ].[ ] **Z4MRT1A**	[ ][ ][ ][ ] **Z4RT1A**	[ ][ ][ ][ ] **Z4MVTD1A**	① Yes ⓪ No → **Z4KP1A** Test other leg. Go to Question #7.
2.	[ ][ ][ ].[ ] **Z4MT2A**	[ ][ ][ ][ ].[ ] **Z4MRT2A**	[ ][ ][ ][ ] **Z4RT2A**	[ ][ ][ ][ ] **Z4MVTD2A**	① Yes ⓪ No → **Z4KP2A** Test other leg. Go to Question #7.
3.	[ ][ ][ ].[ ] **Z4MT3A**	[ ][ ][ ][ ].[ ] **Z4MRT3A**	[ ][ ][ ][ ] **Z4RT3A**	[ ][ ][ ][ ] **Z4MVTD3A**	Test complete. Go to Question #9.

ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

7 What is the length of the lower leg?

(Examiner Note: Only test the other leg if three trials were not possible on the first leg. This should be the length of the other leg to be tested.)

[ ][ ].[ ][ ] meters **Z4LEG2**

8 Which other leg is being tested?

① Right leg ② Left leg ③ Test not performed **Z4RL5**

→ Go to Question #10.

Trial	Maximum Torque (Nm)	Max Rate Torque (Nm/sec)	Reaction Time (msec)	Time to 50% MVTD (msec)	Did participant have knee pain?
1.	[ ][ ][ ].[ ] **Z4MT1B**	[ ][ ][ ][ ].[ ] **Z4MRT1B**	[ ][ ][ ][ ] **Z4RT1B**	[ ][ ][ ][ ] **Z4MVTD1B**	① Yes ⓪ No → **Z4KP1B** STOP. Go to Question #9.
2.	[ ][ ][ ].[ ] **Z4MT2B**	[ ][ ][ ][ ].[ ] **Z4MRT2B**	[ ][ ][ ][ ] **Z4RT2B**	[ ][ ][ ][ ] **Z4MVTD2B**	① Yes ⓪ No → **Z4KP2B** STOP. Go to Question #9.
3.	[ ][ ][ ].[ ] **Z4MT3B**	[ ][ ][ ][ ].[ ] **Z4MRT3B**	[ ][ ][ ][ ] **Z4RT3B**	[ ][ ][ ][ ] **Z4MVTD3B**	Test complete. Go to Question #9.

9 What size connecting rod was used?

① Small ② Medium ③ Large **Z4ROD**

10 Was the participant able to complete the isometric strength test?

① Yes ⓪ No **Z4ISOTST**

→

Why not?

(Examiner Note: Check all that apply.)

-1 Not eligible: bilateral knee replacement **Z4KCBKR3**

-1 Knee pain **Z4KCPN3**

-1 Equipment problems **Z4KCEQ3**

-1 Participant refused **Z4KCREF3**

-1 Participant fatigue **Z4KCFAT3**

-1 Other ***(Please specify:*** **Z4KCOTH3** _____)

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Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

Z4STID10

CORE HOME VISIT WORKBOOK
ULTRASOUND

1 Have you broken any bone in your right leg, ankle, or foot in the past year?
(Examiner Note: Do not include isolated toe fractures.) **Z4BKFOOT**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

↓

Have you broken any bone in your left leg, ankle, or foot in the past year?
(Examiner Note: Do not include isolated toe fractures) **Z4BKLEFT**

① Yes ⓪ No ⑧ Don't know

↓

Which side was most recently broken? **Z4BKSIDE**

① Right → Scan left foot.

② Left → Scan right foot.

⑧ Don't know → Go to question #2.

2 Have you ever broken your right heel bone? **Z4BKRHL**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

↓

Scan left foot.

3 Do you have any permanent weakness in your legs, ankles or feet from an old injury or stroke? **Z4WKLEGS**

① Yes ⓪ No ⑧ Don't know ⑦ Refused

↓

Which side is weaker? **Z4SIDEWK**

① Right → Scan left foot; unless contraindicated in question #1 and #2 above.

② Left → Scan right foot; unless contraindicated in question #1 and #2 above.

③ Right and left are equally weak → Scan right foot.

4 Sahara serial #: **Z4SERIAL**

Draft

5 Which foot was scanned? **Z4BUSCAN**

① Right ② Left ③ Scan not attempted ④ Scan not completed

Why was the left foot scanned? **Z4BULEFT**
- ① Fracture
- ② Permanent weakness on right side
- ③ Hardware
- ④ Other *(Please specify: _____)*

2
3

Why wasn't the scan attempted? **Z4BUCOMP**
- ① Participant refused
- ② Equipment problem
- ③ Foot too big/edema/deformity
- ④ Other *(Please specify:_____)*

Why wasn't the scan completed? **Z4BUNOSC**
- ① Out of range reading
- ② Invalid measurement
- ③ Other *(Please specify:_____)*

6 Measurement #1:

QUI ___.___ units **Z4BUQUI1**

BUA **Z4BUBUA1** ___.___ units → Did BUA result have an asterisk? ① Yes ⓪ No **Z4BUAST1**

SOS **Z4BUSOS1** ___.___ m/s

Measurement #2:

QUI ___.___ units **Z4BUQUI2**

BUA **Z4BUBUA2** ___.___ units → Did BUA result have an asterisk? ① Yes ⓪ No **Z4BUAST2**

SOS **Z4BUSOS2** ___.___ m/s

7 What is the difference between BUA measurement #1 and BUA measurement #2?

___.___ units **Z4BUDIF1**

a. Was the difference between BUA measurement #1 and BUA measurement #2 ≥ 10 units?

① Yes ⓪ No **Z4BUDIF2**

→ Repeat scan and record results in section #8 below.

b. Did both BUA measurement #1 and BUA measurement #2 have an asterisk?

① Yes ⓪ No **Z4BU2AST**

→ Repeat scan and record results in section #8 below.

8

QUI **Z4BUQUI3** ___.___ units

BUA **Z4BUBUA3** ___.___ units → Did BUA result have an asterisk? ① Yes ⓪ No **Z4BUAST3**

SOS **Z4BUSOS3** ___.___ m/s

CORE HOME VISIT WORKBOOK
BONE DENSITY (DXA) SCAN

1 Do you have breast implants?

① Yes ⓪ No **Z4BI**

- Flag scan for review by DXA Reading Center.
- Indicate in the table below whether breast implant is in "Left ribs" or "Right ribs"

2 Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?

① Yes ⓪ No **Z4MO**

a. Flag scan for review by DXA Reading Center.

b. Indicate in the table the location of joint replacement, hardware or other artifacts (sub regions are those defined by the whole body scan analysis.)

Sub	Hardware	Other Artifacts	
Head	①	②	**Z4HEAD**
Left arm	①	②	**Z4LA**
Right arm	①	②	**Z4RA**
Left ribs	①	②	**Z4LR**
Right ribs	①	②	**Z4RR**
Thoracic spine	①	②	**Z4TS**
Lumbar spine	①	②	**Z4LS**
Pelvis	①	②	**Z4PEL**
Left leg	①	②	**Z4LL**
Right leg	①	②	**Z4RL**

CORE HOME VISIT WORKBOOK
BONE DENSITY (DXA) SCAN

3 Have you had any of the following tests within the past ten days?

	Yes	No	
a. Barium enema	1 *	0	**Z4BE**
b. Upper GI X-ray series	1 *	0	**Z4UGI**
c. Lower GI X-ray series	1 *	0	**Z4LGI**
d. Nuclear medicine scan	1 *	0	**Z4NUKE**
e. Other tests using contrast ("dye") or radioactive materials	1 *	0	**Z4OTH2**

(*Examiner Note: If yes to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)

4 Was a bone density measurement obtained for...?

Z4WB

a. Whole Body 1 Yes 0 No

Last 2 characters of scan ID #: **Z4SCAN1** ☐☐

Date of scan: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Z4SCDTE1

Z4HIP

b. Hip 1 Yes 0 No

Last 2 characters of scan ID #: **Z4SCAN2** ☐☐

Date of scan: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Z4SCDTE2

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ / 200 / 2 0 0	
EIID	EIACROS	Month Day EIDATE Year	EISTFID

YEAR 5 VISIT-SPECIFIC HOME VISIT WORKBOOK: COGNITIVE ASSESSMENTS PROCEDURE CHECKLIST

Test	Page #'s	Please check if done				Comments
		Yes: measurement fully completed	Yes: measurement partially completed	No: participant refused	No: other reason	
1. Teng mini-mental state	**2**	①	③	⓪	②	EITMM
2. Digit symbol substitution	**8**	①	③	⓪	②	EIDSS
3. CLOX 1	**10**	①	③	⓪	②	EICLOX

Interviewer Note: If the annual Year 5 contact is completed over the telephone, administer the following:

1. **The ☆ questions in the attached Teng mini-mental state exam (pages #2 through #7).**
2. **The appropriate sections of the Core Home Visit Workbook.**
3. **Year 5 Core Home Visit-specific Worksheet: Hip Pain.**
4. **Year 5 Core Home Visit-specific Knee X-ray Eligibility Assessment.**

EILINK

Page Link #

Annotated: 8/20/2001 pjm
Y5 VSHVWCA Version 1.0, 8/20/2001 pjm

Draft

Teng Mini-Mental State Exam

Are you comfortable? I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once.

(Examiner Note: Record responses. If the participant does not answer, mark the "No response" option.)

1 When were you born? EIBORNRF

a. EIBORNM Month / b. EIBORND Day / c. EIBORNY Year ① No response

Where were you born? (Place of Birth?)

	Answer given	Can't do/ Refused	Not attempted/ disabled
d. City/town	①	⑦ EICITY	③
e. State/Country	①	⑦ EISTE	③

Examiner Note: Ask again in Question #18.

2 I am going to say three words for you to remember. Repeat them after I have said all three words:

Shirt, Blue, Honesty

(Examiner Note: Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.)

	Correct	Error/ Refused	Not attempted/ disabled
a. Shirt	EISHRT ①	⑦	③
b. Blue	EIBLU ①	⑦	③
c. Honesty	EIHON ①	⑦	③

d. Numbers of presentations necessary for the participant to repeat the sequence: ☐ EINUM presentations

3 a. I would like you to count from 1 to 5. EICNT

① Able to count forward ② Unable to count forward *Say 1-2-3-4-5*

b. Now I would like to you count backwards from 5 to 1. Record the responses in the order given: ***(Examiner Note: Enter "99999" if no response)*** EICNTBK ☐☐☐☐☐

4 a. Spell "world." EISPL

① Able to spell ② Unable to spell "It's spelled W-O-R-L-D."

b. Now spell "world" backwards ***(Examiner Note: Record letter in order given. Enter "xxxxx" if no response.)*** EISPWLD ☐☐☐☐☐

COGNITIVE FUNCTION

5 What three words did I ask you to remember earlier?

(Examiner Note: The words may be repeated in any order. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices, score "Unable to recall/refused" and provide the correct answer.)

a. Shirt

EISHRM
- 1 Spontaneous recall
- 2 Correct word/incorrect form
- 3 After "Something to wear"
- 4 After "Was it shirt, shoes, or socks?"
- 7 Unable to recall/refused (provide the correct answer)
- 6 Not attempted/disabled

b. Blue

EIBLRM
- 1 Spontaneous recall
- 2 Correct word/incorrect form
- 3 After "A color"
- 4 After "Was it blue, black, or brown?"
- 7 Unable to recall/refused (provide the correct answer)
- 6 Not attempted/disabled

c. Honesty

EIHNRM
- 1 Spontaneous recall
- 2 Correct word/incorrect form
- 3 After "A good personal quality"
- 4 After "Was it honesty, charity, or modesty?"
- 7 Unable to recall/refused (provide the correct answer)
- 6 Not attempted/disabled

6 **a.** What is today's date?
(Examiner Note: If the participant does not answer, mark the "No response" option.)

EITDAYM / EITDAYD / EITDAYY — 1 No response
Month / Day / Year — EITDAYRF

b. What is the day of the week?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

EIDAYWK — Day of the week

c. What season of the year is it?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

EISEAS — Season

7 **a.** What state are we in?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

EISTAT — State

b. What county are we in?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

EICNTY — County

c. What (city/town) are we in?
(Examiner Note: Write answer if incorrect. Enter 'X' if no response.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

EICITN — City/town

d. Are we in a clinic, store, or home?
(Examiner Note: If correct answer is not among the three alternatives [e.g., hospital or nursing home], substitute it for the middle alternative [store]. If the participant states that none is correct, ask them to make the best choice of the three options.)
- 1 Correct
- 7 Error/refused
- 3 Not attempted/disabled

EIWHRE

COGNITIVE FUNCTION

8 ***(Examiner Note: Point to the object or a part of your own body and ask the participant to name it. Score "Error/Refused" if the participant cannot name it within 2 seconds or gives an incorrect name. Do not wait for the participant to mentally search for the name.)***

	Correct	Error/ Refused	Not attempted/ disabled
a. Pencil: What is this? EIPENC	1	7	3
b. Watch: What is this? EIWTCH	1	7	3
c. Forehead: What do you call this part of the face? EIFRHD	1	7	3
d. Chin: And this part? EICHIN	1	7	3
e. Shoulder: And this part of the body? EISHLD	1	7	3
f. Elbow: And this part? EIELB	1	7	3
g. Knuckle: And this part? EIKNK	1	7	3

9 What animals have four legs?
Tell me as many as you can.

(Examiner Note: Discontinue after 30 seconds. Record the total number of correct responses. If the participant gives no response in 10 seconds and there are still at least 10 seconds remaining, gently remind them [once only]).
"What (other) animals have four legs?"
The first time an incorrect answer is provided, say,
"I want four-legged animals."
Do not correct for subsequent errors.

Score (total correct reponses): EISCR

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

(Examiner Note: Write any additional correct answers on a separate sheet of paper.)

10 ***(Examiner Note: If the initial response is scored "Lesser correct answer" or "Error," coach the participant by saying: "An arm and a leg are both limbs or extremities" to reinforce the correct answer. Coach only for Question #10a. No other prompting or coaching is allowed.)***

a. In what way are an arm and a leg alike?

EIARLG
1 Limbs, extremities, appendages
2 Lesser correct answer (e.g., body parts, both bend, have joints)
7 Error/refused (e.g., states differences, gives unrelated answer)
3 Not attempted/disabled

b. In what way are laughing and crying alike?

EILCRY
1 Expressions of feelings, emotions
2 Lesser correct answer (e.g., sounds, expressions, other similar responses)
7 Error/refused (e.g., states differences, gives unrelated answer)
3 Not attempted/disabled

c. In what way are eating and sleeping alike?

EIETSL
1 Necessary bodily functions, essential for life
2 Lesser correct answer (e.g., bodily functions, relaxing, good for you or other similar responses)
7 Error/refused (e.g. states differences, gives unrelated answer)
3 Not attempted/disabled

11 Repeat what I say: **"I would like to go out."**
(Examiner Note: Pronounce the individual words distinctly but with normal tempo of a spoken sentence.)

EIRPT
1 Correct
2 1 or 2 words missed
7 3 or more words missed/refused
3 Not attempted/disabled

12 Now repeat: **"No ifs, ands or buts."**

(Examiner Note: Pronounce the individual words distinctly but with normal tempo of a spoken sentence. Give no credit if the participant misses the "s.")

	Correct	Error/ Refused	Not attempted/ disabled
a. no ifs	1	7 EIIF	3
b. ands	1	7 EIAND	3
c. or buts	1	7 EIBUT	3

13 ***Examiner Note: Hold up Card C and say,***
"Please do this."

If the participant does not close their eyes within 5 seconds, prompt by pointing to the sentence and saying

"Read and do what this says."

If the participant has already read the sentence aloud spontaneously, simply say,

"Do what this says."

Allow 5 seconds for the response. Assign the appropriate score (see below). As soon as the participant closes their eyes, say

"Open."

EICRD1
1 Closes eyes without prompting
2 Closes eyes after prompting
3 Reads aloud, but does not close eyes
7 Does not read aloud or close eyes/refused
5 Not attempted/disabled

14 Please write the following sentence:
I would like to go out.

(Examiner Note: Hand participant a piece of blank paper and a #2 pencil with eraser. If necessary, repeat the sentence word by word as the participant writes. Allow a maximum of 1 minute after the first reading of the sentence for scoring the task. Either printing or cursive writing is allowed. Score "Correct" for each correct word, but no credit for "I". For each word, score "Error/Refused" if there are spelling errors or incorrect mixed capitalizations (all letters printed in uppercase are permissible). Self-corrected errors are acceptable.)

	Correct	Error/ Refused	Not attempted/ disabled
a. would	1	7 EIWLD	3
b. like	1	7 EILKE	3
c. to	1	7 EITO	3
d. go	1	7 EIGO	3
e. out	1	7 EIOUT	3

(Examiner Note: Note which hand the participant uses to write. If this task is not done, ask participant if they are right or left handed. [Use in Question #16])

1 Right
EIHAND 2 Left
8 Unknown

15 Here is a drawing. Please copy the drawing onto this piece of paper.

(Examiner Note: Hand participant Card D. Allow 1 minute for copying. For right-handed participants, present the sample on the left side; for left-handed participants, present the sample on the right side. Allow a maximum of 1 minute for response. Do not penalize for self-corrected errors, tremors, minor gaps, or overshoots.)

a. Pentagon 1

EIPENT1
- ① 5 approximately equal sized
- ② 5 sides, but longest:shortest side is >2:1
- ③ nonpentagon enclosed figure
- ④ 2 or more lines, but it is not an enclosed figure
- ⑦ less than 2 lines/refused
- ⑥ not attempted/disabled

b. Pentagon 2

EIPENT2
- ① 5 approximately equal sized
- ② 5 sides, but longest:shortest side is >2:1
- ③ nonpentagon enclosed figure
- ④ 2 or more lines, but it is not an enclosed figure
- ⑦ less than 2 lines/refused
- ⑥ not attempted/disabled

c. Intersection

EIINT
- ① 4-cornered enclosure
- ② not a 4-cornered enclosure
- ⑦ no enclosure/refused
- ④ not attempted/disabled

16 ***(Examiner Note: Refer to Question #14 to check whether the participant is right- or left-handed. Ask them to take the paper in their non-dominant hand.)***

"Take this paper with your left (right for left handed person) hand, fold it in half using both hands, and hand it back to me."

(Examiner Note: After saying the whole command, hold the paper within reach of the participant. Do not repeat any part of the command. Do not move the paper toward the participant. The participant may hand back the paper with either hand.)

	Correct	Error/ Refused	Not attempted/ disabled
a. Takes paper in correct hand	①	⑦	③
EIPCOR			
b. Folds paper in half	①	⑦	③
EIPFLD			
c. Hands paper back	①	⑦	③
EIPHND			

COGNITIVE FUNCTION

17 What three words did I ask you to remember earlier?

(Examiner Note: Administer this item even when the participant scored one or more "unable to recall/refused" on Question #5. The words may be repeated in any order. For each word not readily given, provide the category followed by multiple choices when necessary. Do not wait more than 3 seconds for spontaneous recall and do not wait more than 2 seconds after category cueing before providing the next level of help.)

a. Shirt

EISH2
- ① Spontaneous recall
- ② Correct word/incorrect form
- ③ After "Something to wear"
- ④ After "Was it shirt, shoes, or socks?"
- ⑦ Unable to recall/refused (provide the correct answer)
- ⑥ Not attempted/disabled

b. Blue

EIBLU2
- ① Spontaneous recall
- ② Correct word/incorrect form
- ③ After "A color"
- ④ After "Was it blue, black, or brown?"
- ⑦ Unable to recall/refused (provide the correct answer)
- ⑥ Not attempted/disabled

c. Honesty

EIHON2
- ① Spontaneous recall
- ② Correct word/incorrect form
- ③ After "A good personal quality"
- ④ After "Was it honesty, charity, or modesty?"
- ⑦ Unable to recall/refused (provide the correct answer)
- ⑥ Not attempted/disabled

18 Would you please tell me again where you were born?

(Examiner Note: Ask this question only when a response was given in Question #1d and #1e. Score the response by checking against the response in Question #1d and #1e.)

Place of Birth?		Matches	Does not match/ Refused	Not attempted/ disabled
a. _____ City/town	EICITY2	①	⑦	③
b. _____ State/Country	EISTE2	①	⑦	③

19 ***(Examiner Note: If physical/functional disabilities or other problems exist which cause the participant difficulty in completing any of the tasks, record the nature of the problem listed below. Mark <u>all</u> that apply.)***

- -1 Vision **EIVIS**
- -1 Hearing **EIHEAR**
- -1 Writing problems due to injury or illness **EIWRITE**
- -1 Illiteracy or lack of education **EIILLIT**
- -1 Language **EILANG**
- -1 Other ***(Please record the specific problem in the space provided.)*** **EIOTH** _____

DIGIT SYMBOL SUBSTITUTION

❶ *Determine if participant wears glasses for reading.*

Script: "Do you usually wear glasses to read?" ① Yes → Ask the participant to put on their glasses.

EIGLS ⓪ No

❷ *Place the task sheet before the participant and point to the task.*

Script: "Look at these boxes across the top of the page. On the top of each box is a number from one through nine. On the bottom part of each box there is a symbol. Each symbol is paired with a number."

❸ *Point to the four rows of boxes.*

Script: "Down here are boxes with numbers on the top, but the bottom part is blank. What I want you to do is to put the correct symbol in each box like this."

❹ *Fill in the first three sample boxes.*

Script: "Now I want you to fill in all boxes up to this line."

❺ *Point to the line separating the samples from the test proper.*

EITST

① Sample completed → Go on to timed test.

② Unable to complete sample → Do NOT go on to timed test. Write in "00" below for Number Completed and "00" for Number Incorrect.

⑦ Refused → Do NOT go on to timed test. Do not score.

③ Unable to test (arthritis, poor vision, etc.) → Do NOT go on to timed test. Do not score.

Script: "When I tell you to begin, start here and fill in the boxes in these four rows. Do them in order and don't skip any. Please try to work as quickly as possible. Let's begin."

Stop the participant after 90 seconds. Say:

Script: "That's good. That completes this set of tasks."

Score: ***(Examiner Note: Use Card E to score test.***
DO NOT COUNT ANY SYMBOLS AFTER TWO BLANKS IN A ROW)

Number Completed: ☐☐ **EINC** Number Incorrect: ☐☐ **EINI**

CLOX 1

Examiner Note: Place a plain white sheet of paper in front of the participant and say:

Script: "Draw me a clock that says 1:45. Set the hands and numbers on the face so that a child could read them."

1.	Does figure resemble a clock?	1 Yes 0 No	**EICLX01**
2.	Is a circular face present?	1 Yes 0 No	**EICLX02**
3.	Are the dimensions >1 inch?	1 Yes 0 No	**EICLX03**
4.	Are all numbers inside the perimeter?	1 Yes 0 No	**EICLX04**
5.	Is there sectoring or are there tic marks?	1 Yes 0 No	**EICLX05**
6.	Were 12, 6, 3, & 9 placed first?	1 Yes 0 No	**EICLX06**
7.	Is the spacing intact? (Symmetry on either side of 12 o'clock and 6 o'clock?)	1 Yes 0 No	**EICLX07**
8.	Were only Arabic numerals used?	1 Yes 0 No	**EICLX08**
9.	Are only the numbers 1 through 12 among the numerals present?	1 Yes 0 No	**EICLX09**
10.	Is the sequence 1 through 12 intact? (No omissions or intrusions.)	1 Yes 0 No	**EICLX10**
11.	Are there exactly 2 hands present? (Ignore sectoring/tic marks)	1 Yes 0 No	**EICLX11**
12.	Are all hands represented as arrows?	1 Yes 0 No	**EICLX12**
13.	Is the hour hand between 1 o'clock and 2 o'clock?	1 Yes 0 No	**EICLX13**
14.	Is the minute hand obviously longer than the hour hand?	1 Yes 0 No	**EICLX14**
15.	Are there any of the following...?		
	a) Hand pointing to 4 or 5 o'clock?	1 Yes 0 No	**EICLX15A**
	b) "1:45" present?	1 Yes 0 No	**EICLX15B**
	c) Any other notation (e.g. "9:00")?	1 Yes 0 No	**EICLX15C**
	d) Any arrows point inward?	1 Yes 0 No	**EICLX15D**
	e) Intrusions from "hand" or "face" present?	1 Yes 0 No	**EICLX15E**
	f) Any letters, words or pictures?	1 Yes 0 No	**EICLX15F**

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
EFID	EFACROS	EFDATE	EFSTFID

YEAR 5 CORE HOME VISIT-SPECIFIC WORKSHEET: HIP PAIN

Now I am going to ask you a question about pain in your hip. In the past 12 months, have you had hip pain on most days for at least one month? This includes pain in the groin and either side of the upper thigh. Do not include pain that was only in your lower back or buttocks.
(Examiner Note: REQUIRED - Show Figure below.)

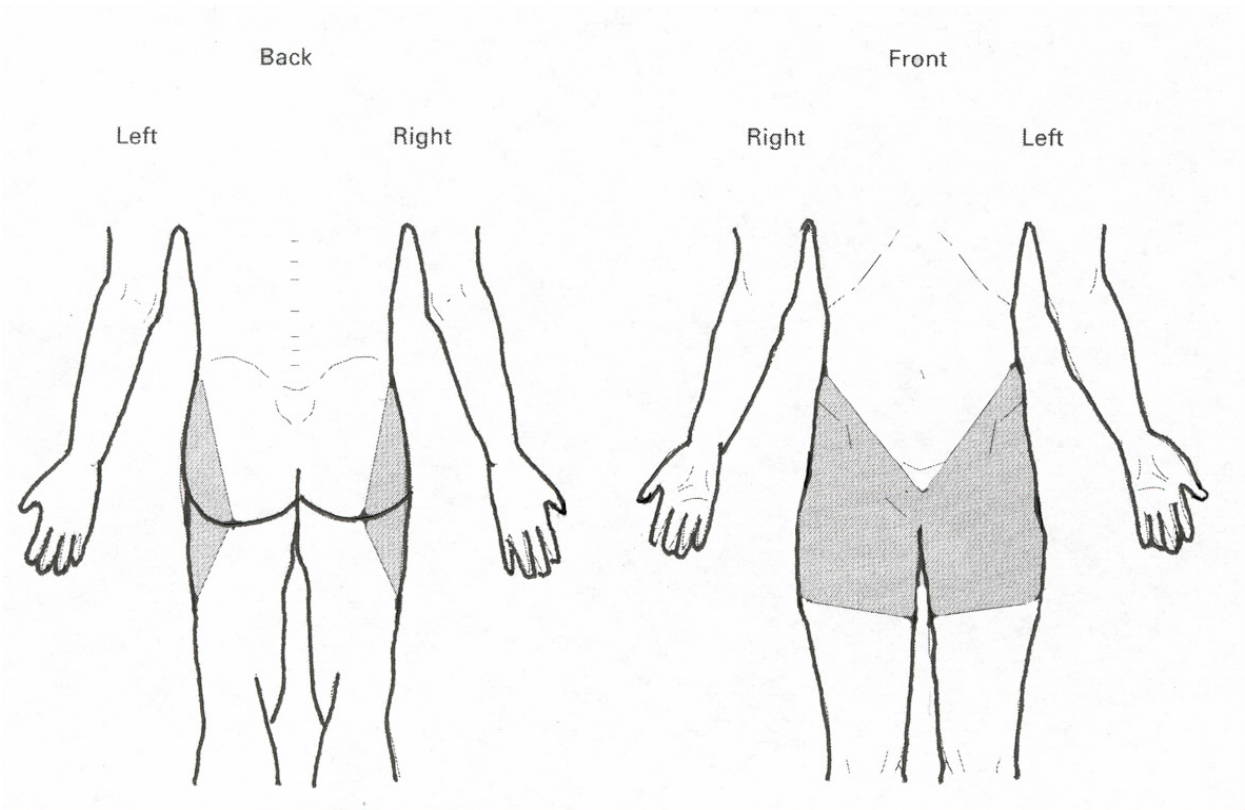
EFAJH30D ① Yes ⓪ No ⑧ Don't know ⑦ Refused

In the past 12 months, have you had this pain in the right hip, left hip or both hips?

② Right hip only

EFAJH12M ① Left hip only

③ Both right and left hip



Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / 200 Year	
YAID	YAACROS	YADATE	YASTFID

PROXY INTERVIEW

Month or Year of Contact:

YAVISIT

- ③ Year 3 annual contact
- **30** ○ 30-month semi-annual contact
- ④ Year 4 annual contact
- **42** ○ 42-month semi-annual contact
- ⑤ Year 5 annual contact
- **54** ○ 54-month semi-annual contact
- ⑥ Year 6 annual contact
- **66** ○ 66-month semi-annual contact
- ⑦ Year 7 annual contact
- **78** ○ 78-month semi-annual contact
- ⑧ Other ***(Please specify)*** _____

Type of Contact: **YACONTAC**

- ① Home (face-to-face interview)
- ④ Clinic (face-to-face interview)
- ⑤ Nursing home (face-to-face interview)
- ② Telephone interview
- ③ Other ***(Please specify)*** _____

YADATES

Date of last regularly scheduled contact: ☆ = **Semi-annual telephone contact questions**

Month / Day / Year

Interviewer Note: Ask all questions for annual contact. Ask only ☆ questions during semi-annual telephone contact.

☆ **1.** What is your relationship to *(name of Health ABC participant)*?

YAREL

- ① Spouse or partner
- ② Child
- ③ Family member (other than spouse or child) ***(Please specify:*** _____ ***)***
- ④ Close friend
- ⑤ Health care provider
- ⑥ Other ***(Please specify:*** **YARELOTH** _____ ***)***
- ⑦ Refused

☆ **2.** How often do you have contact with *(him/her)*?
(Interviewer Note: Please mark only one answer.)

YACONFRQ

- ① Live together → Go to Question #4
- ② Daily (but does not live together)
- ③ 3 or more times a week
- ④ Less than 3 times a week
- ⑧ Don't know
- ⑦ Refused

YALINK

3. What is the most frequent type of contact?

YACONTYP
① Mostly in person
② Mostly by phone
③ Both in person and by phone
④ Other ***(Please specify:*** _____ ***)***
⑧ Don't know
⑦ Refused

4. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* stay in bed all or most of the day because of an illness or injury? Please include days that *(he/she)* was a patient in a hospital.

YABED ① Yes ⓪ No ⑧ Don't know ⑦ Refused

About how many days did *(he/she)* stay in bed all or most of the day because of an illness or injury? Please include days that *(he/she)* was a patient in a hospital.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

YABEDDAY ☐☐☐ days

5. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* cut down on the things *(he/she)* usually did, such as going to work or working around the house, because of an illness or injury? Please include days in bed.

YACUT ① Yes ⓪ No ⑧ Don't know ⑦ Refused

How many days did *(he/she)* cut down on the things *(he/she) usually did because of illness or injury? Please include days in bed.*
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

YACUTDAY ☐☐☐ days

6. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* stay overnight as a patient in a nursing home or rehabilitation center?

YAMCNH ① Yes ⓪ No ⑧ Don't know ⑦ Refused

7. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, did *(he/she)* receive care at home from a visiting nurse, home health aide, or nurse's aide?

YAMCVN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Now I'm going to ask you about some medical problems that *(name of Health ABC participant)* might have had in the past 12 months.

In the past 12 months, was *(name of Health ABC participant)* told by a doctor that *(he/she)* had...?

8. Hypertension or high blood pressure? We are specifically interested in hearing about hypertension or high blood pressure that was diagnosed for the first time in the past 12 months.

YAHCHBP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

---

9. Diabetes or sugar diabetes? Again, we are specifically interested in hearing about diabetes that was diagnosed for the first time in the past 12 months.

YASGDIAB ① Yes ⓪ No ⑧ Don't know ⑦ Refused

---

10. In the past 12 months, has *(name of Health ABC participant)* fallen and landed on the floor or ground?

YAAJFALL ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Please go to Question #11

How many times has *(he/she)* fallen in the past 12 months? If you are unsure, please make your best guess.

YAAJFNUM
① One
② Two or three
④ Four or five
⑥ Six or more
⑧ Don't know

PROXY INTERVIEW

Now I'm going to ask about some medical problems *(name of Health ABC participant)* might have had since we last spoke to *(him/her)* about 6 months ago, which was on ☐☐ / ☐☐ / ☐☐☐☐ Month Day Year

11. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had a heart attack, angina, or chest pain due to heart disease?

YAHCHAMI ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Was *(he/she)* hospitalized overnight for this problem?

YAHOSMI ① Yes

→ Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a. ☐☐☐☐☐ **YAREF11A**

b. ☐☐☐☐☐ **YAREF11B**

c. ☐☐☐☐☐ **YAREF11C**

⓪ No → Go to Question #12

---

12. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had a stroke, mini-stroke, or TIA?

YAHCCVA ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Was *(he/she)* hospitalized overnight for this problem?

YAHOSMI2 ① Yes

→ Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a. ☐☐☐☐☐ **YAREF12A**

b. ☐☐☐☐☐ **YAREF12B**

c. ☐☐☐☐☐ **YAREF12C**

⓪ No → Go to Question #13

---

13. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had congestive heart failure?

YACHF ① Yes ⓪ No ⑧ Don't know ⑦ Refused

→ Was *(he/she)* hospitalized overnight for this problem?

YAHOSMI3 ① Yes

→ Complete a Health ABC Event Form, Section I, for each overnight hospitalization. Record reference #'s below:

a. ☐☐☐☐☐ **YAREF13A**

b. ☐☐☐☐☐ **YAREF13B**

c. ☐☐☐☐☐ **YAREF13C**

⓪ No → Go to Question #14

14. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had cancer? We are specifically interested in hearing about a cancer that was diagnosed for the first time since we last spoke to *(him/her)*.

YACHMGMT ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. | | | | | | **YAREF14A**

b. | | | | | | **YAREF14B**

c. | | | | | | **YAREF14C**

15. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she)* had pneumonia?

YALCPNEU ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. | | | | | | **YAREF15A**

b. | | | | | | **YAREF15B**

c. | | | | | | **YAREF15C**

16. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, was *(he/she)* told by a doctor that *(he/she*) broke or fractured a bone(s)?

YAOSBR45 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section II, for each event.
Record reference #'s below:

a. | | | | | | **YAREF16A**

b. | | | | | | **YAREF16B**

c. | | | | | | **YAREF16C**

17. Was *(name of Health ABC participant)* hospitalized overnight for any other reasons since we last spoke to *(him/her)* about 6 months ago?

YAHOSP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Complete a Health ABC Event Form, Section I, for each event.
Record reference #'s and reason for hospitalization below.

a. **YAREF17A** Reason for hospitalization: _____

b. **YAREF17B** Reason for hospitalization: _____

c. **YAREF17C** Reason for hospitalization: _____

d. **YAREF17D** Reason for hospitalization: _____

e. **YAREF17E** Reason for hospitalization: _____

f. **YAREF17F** Reason for hospitalization: _____

18. Has *(name of Health ABC participant)* had any same day outpatient surgery since we last spoke to *(him/her)* about 6 months ago?

YAOUTPA ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Was it for. . .?

a. A procedure to open a blocked artery — ① Yes ⓪ No **YABLART** ⑧ Don't know → ***Complete a Health ABC Event Form, Section III. Record reference #:*** ***Reference #*** **YAREF18A**

b. Gall bladder surgery — ① Yes ⓪ No **YAGALLBL** ⑧ Don't know

c. Cataract surgery — ① Yes ⓪ No **YACATAR** ⑧ Don't know

d. Hernia repair (Inguinal abdominal hernia.) — ① Yes ⓪ No **YAHERN** ⑧ Don't know

e. TURP (MEN ONLY) (transurethral resection of prostate) — ① Yes ⓪ No **YATURP** ⑧ Don't know

f. Other — ① Yes ⓪ No **YAOTH** ⑧ Don't know →

Please specify the type of outpatient surgery.

i. _____

ii. _____

iii. _____

19. Is there any other illness or condition for which *(name of Health ABC participant)* sees a doctor or other health care professional?

YAOTILL ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Please go to Question #20

Please describe for what:

_____

_____

_____

20. Does *(name of Health ABC participant)* have any problems with *(his/her)* memory?

YAMEM ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Please go to Question #21

a. Did *(his/her)* trouble with memory begin suddenly or slowly?

YAMEMBEG
① Suddenly
② Slowly
⑧ Don't know

b. Has the course of memory problems been a steady downhill progression, an abrupt decline, stayed the same, or gotten better?

YAMEMPRG
① Steady downhill progression
② Abrupt decline
③ Stayed the same (no decline)
④ Gotten better
⑧ Don't know

c. Is a doctor aware of *(his/her)* memory problems?

YAMEMDR ① Yes ⓪ No ⑧ Don't know

What does the doctor believe is causing *(his/her)* memory problems?
(Interviewer Note: Please mark only <u>one</u> answer.)

YAMEMPRB
① Alzheimer's disease
② Confusion
③ Delerium
④ Dementia
⑤ Depression
⑥ Multiinfarct
⑦ Parkinson's disease
⑨ Stroke
10 ○ Nothing wrong
11 ○ Other ***(Please specify)*** _____
⑧ Don't know

21. Because of a health or physical problem, does *(name of Health ABC participant)* have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks?
(Interviewer Note: If the proxy responds "Doesn't do," probe to determine whether this was because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, mark "Yes." If the participant doesn't walk for other reasons, mark "Does not do.")

YADWQMYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused ⑨ Does not do

→ Go to Question #22

How much difficulty does *(he/she)* have?
(Interviewer Note: Read response options.)

YADWQMDF
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are they unable to do it?
⑧ Don't know

---

22. Because of a health or physical problem, does *(name of Health ABC participant)* have any difficulty walking up 10 steps, that is about 1 flight, without resting?
(Interviewer Note: If the proxy responds "Doesn't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, mark "Yes." If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, mark "Does not do.")

YADW10YN ① Yes ⓪ No ⑧ Don't know ⑦ Refused ⑨ Does not do

→ Go to Question #23

How much difficulty does *(he/she)* have?
(Interviewer Note: Read response options.)

YADIF
① A little difficulty
② Some difficulty
③ A lot of difficulty
④ Or are they unable to do it?
⑧ Don't know

23. Does *(name of Health ABC participant)* have to use a cane, walker, crutches, or other special equipment to help *(him/her)* get around?

YAEQUIP ① Yes ⓪ No ⑧ Don't know ⑦ Refused

24. Because of a health or physical problem, does *(name of Health ABC participant)* have any difficulty getting in and out of bed or chairs?

YADIOYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. How much difficulty does *(he/she)* have?
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YADIODIF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does *(he/she)* usually receive help from another person when *(he/she)* gets in and out of bed or chairs?

YADIORHY ① Yes ⓪ No ⑧ Don't know

25. Does *(name of Health ABC participant)* have any difficulty bathing or showering?

YABATHYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. How much difficulty does *(he/she)* have?
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YABATHDF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does *(he/she)* usually receive help from another person in bathing or showering?

YABATHRH ① Yes ⓪ No ⑧ Don't know

26. Does *(name of Health ABC participant)* have any difficulty dressing?

YADDYN ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. How much difficulty does *(he/she)* have?
(Interviewer Note: Read response options.)

① A little difficulty

② Some difficulty

YADDDIF ③ A lot of difficulty

④ Or are they unable to do it?

⑧ Don't know

b. Does *(he/she)* usually receive help from another person in dressing?

YADDRHYN ① Yes ⓪ No ⑧ Don't know

---

27. In general, would you say that *(name of Health ABC participant's)* appetite or desire to eat has been. . . ?
(Interviewer Note: Read response options.)

YAAPPET

① Very good

② Good

③ Moderate

④ Poor

⑤ Very poor

⑧ Don't know

⑦ Refused

---

28. Since we last spoke to *(name of Health ABC participant)* about 6 months ago, has *(his/her)* weight changed by 5 or more pounds?
(Interviewer Note: We are interested in net gain or loss during the past 6 months. In other words, is the participant either 5 or more pounds heavier or lighter than they were 6 months ago?)

YACHN5LB ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. Did *(he/she)* gain or lose weight?
(Interviewer Note: We are interested in net gain or loss during the past 6 months.)

YAGNLS ① Gain ② Lose ⑧ Don't know

b. How many pounds did *(he/she)* gain/lose in the past 6 months?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

YAHOW6 ☐☐ pounds ⑧ Don't know **YAHOW6DN**

29. Has *(name of Health ABC participant)* changed *(his/her)* doctor or place that *(he/she)* usually goes for health care or advice about *(his/her)* health care in the past 12 months?

YAHCADV ① Yes ⓪ No ② *(He/she)* doesn't have a doctor or place that *(he/she)* usually goes for health care ⑧ Don't know ⑦ Refused

Interviewer Note:
- ***If Year 3, go to Questions #29a and #29b.***
- ***If Year 4-7, go to Question #30.***

a. Where does *(name of Health ABC participant)* usually go for health care or advice about health care?
(Interviewer Note: Read response options. Please mark only one answer.)

YAHCSRC

① Private doctor's office (individual or group practice)

② Public clinic such as a neighborhood health center

③ Health Maintenance Organization (HMO) ***(Please specify:*** YAHCHMO ______ ***)***
(Examples: Security Blue, US Healthcare, Health America, The Apple Plan, Omnicare, Prucare)

④ Hospital outpatient clinic

⑤ Emergency room

⑥ Other ***(Please specify:*** YAHCOTH ______ ***)***

b. Please tell me the name, address, and telephone number of the doctor or place that *(name of Health ABC participant)* usually goes to for health care.

First Name: ______ YADFNAME

Last Name: ______ YADLNAME

Street Address: ______ YADSTRT

City: ______ YADCITY State: ______ YADSTATE

Zip Code: ______ - ______ YADZIP

Telephone: (______) ______ - ______ YADPHONE
Area Code Number

30. We would like to update all of *(name of Health ABC participant's)* contact information this year. The address that we currently have listed for *(name of Health ABC participant)* is:
(Interviewer Note: Please read address from the Data from Prior Visits Report)

Please tell me if the information I have is still correct.

(Interviewer Note: If Year 3, clearly record correct address FOR ALL PARTICIPANTS below, even if contact information has not changed from previous years. If Year 4-Year 7, record address only if it needs to be corrected and/or updated.)

YAFNAME
First Name

YALNAME
Last Name

YASTREET
Street Address

YAAPT
Apt/Room

YACITY
City

YASTATE
State

YAZIP
Zip Code

The telephone number(s) that we currently have for *(name of Health ABC participant)* is *(are)*
(Interviewer Note: Please read telephone number(s) from the Data from Prior Visits Report):

Please tell me if these telephone numbers are correct.

(Interviewer Note: If Year 3, clearly record correct telephone number(s) FOR ALL PARTICIPANTS below, even if contact information has not changed from previous years. If Year 4-Year 7, record telephone number (s) only if they need to be corrected and/or updated.)

Home Telephone #: ( ) - **YAPHONE**
Area Code Number

Work Telephone #: ( ) - **YAWKPHON**
Area Code Number

31. Do you expect *(name of Health ABC participant)* to move or have a different mailing address in the next 6 months?

Yes ① No ⓪ Don't know ⑧ Refused ⑦ **YAMOVE**

Do you know what *(his/her)* new mailing address will be?

Yes ① No ⓪ **YAMOVE2**

What will be *(his/her)* new mailing address?

YAMASTRT

Street Address

YAMAAPT

Apt/Room

YAMACITY **YAMASTATE**

City State

YAMAZIP

Zip Code

① Permanent address
② Winter address
④ Summer address
③ Other *(Please describe: _____)*

YAADDRES

Telephone: **YAMATELE**

( ) -

Area Code Number

Date new address/phone number effective:

/ / **YAMADATE**

Month Day Year

32. ***Interviewer Note: Please answer the following question based on your judgment of the proxy's responses to the Proxy Interview.***

On the whole, how reliable do you think the proxy's responses to the Proxy Interview are?

YARELY

① Very reliable

② Fairly reliable

③ Not very reliable

⑧ Don't know

33. What is the primary reason a proxy was contacted for the Semi-Annual Telephone Interview or Annual Contact? Please mark only one reason.

① Illness/health problem(s)

② Hearing difficulties

③ Cognitive difficulties

YAPROXY

④ In nursing home/long-term care facility

⑤ Refused to give reason

YAPROXOT

⑥ Other ***(Please specify:*** [ ] ***)***

Thank you very much for answering these questions. Please remember to call us if *(name of Health ABC participant)* is admitted to a hospital or nursing home for any reason so that we can better understand changes in *(his/her)* health. We would also like to hear from you if *(name of Health ABC participant)* moves or if *(his/her)* mailing address changes. We will be calling you in about 6 months from now to find out how *(name of Health ABC participant)* has been doing.

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
YBID	YBACROS	YBDATE	YBSTFID

PROXY CONTACT HOME VISIT WORKBOOK

Year of Contact:

YBVISIT

③ Year 3 annual contact
④ Year 4 annual contact
⑤ Year 5 annual contact
⑥ Year 6 annual contact
⑦ Year 7 annual contact
⑧ Other *(Please specify)* _____

PROXY CONTACT HOME VISIT PROCEDURE CHECKLIST

Measurement	Page #	Yes: Measurement fully completed	Yes: Measurement partially completed	No: Participant/Proxy refused	No: Other reason/ Not Applicable
1. Was the Proxy Interview completed?		①	③	⓪	② YBPROXY
2. Medication inventory update	2	①	③	⓪	② YBMI
3. Weight	7	①	③	⓪	② YBWT
4. Radial pulse	7	①	③	⓪	② YBRP
5. Blood pressure	8	①	③	⓪	② YBBP
6. Grip strength	9	①	③	⓪	② YBGRIP
7. Chair stands	11	①	③	⓪	② YBCS
8. Standing balance	12	①	③	⓪	② YBSB
9. 4-meter walk	14	①	③	⓪	② YB4MW
10. Knee crepitus	16	①	③	⓪	② YBKNEE
11. Isometric strength (Isometric chair)	17	①	③	⓪	② YBISO
12. Ultrasound	20	①	③	⓪	② YBULTRA
13. Bone density (DXA) scan	22	①	③	⓪	② YBDXA
14. Was blood collected?		①	③	⓪	② YBBLOOD
15. Was urine collected?		①	③	⓪	② YBURINE
16. Was participant scheduled for an x-ray?		①	③	⓪	② YBXR

YBLINK

Page Link #

Annotated: 6/15/00 pjm
HABC Prox Home Visit, Version 1.0, 6/12/00 pjm

Draft

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
MAID/MIFIF	MAACROS	MIFDATE/MADATE	MASTAFF

PROXY CONTACT HOME VISIT MEDICATION INVENTORY FORM -- Page A

Section A Medication Reception

Refer to *Data From Prior Visits Report*. Ask the proxy if the participant has used each prescription and over-the-counter medication listed on *Data From Prior Visits Report* within the past 2 weeks. Record on the *Proxy Contact Medication Inventory Form* all prescription and over-the-counter medications (including pills, dermal patches, eye drops, creams, salves, and injections) used in the previous two weeks, even if already listed on the *Data From Prior Visits Report*. If possible, record the complete drug name exactly as written on the container label. Confirm strength, units, number used, etc.

"We are interested in all the prescription and over-the-counter medications that (name of Health ABC participant) took during the past 2 weeks. We are also interested in drugs not usually prescribed by a doctor, such as supplements, vitamins, pain medications, laxatives or bowel medicines, cold and cough medications, antacids or stomach medicines, and ointments or salves."

Did the participant take any prescription or non-prescription medications in the past 2 weeks?

MAMEDS [1] Yes [0] No [8] Don't know [7] Refused

Section B Prescription Medication.

Copy the name of the prescription, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1.	MIFNAME	MIF STRE N	MIF UNIT	MIFDWM ____ D W M	[1] Y [0] N MIFPRN	[1] Y [0] N MIFSEEN [X] Rx 1 [ ] Non Rx
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	
2.	MIFNAME			____ D W M	[ ] Y [ ] N	[ ] Y [ ] N [X] Rx [ ] Non Rx
	Reason for use:			Date Started: Month / Year	Formulation Code:	
3.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N [X] Rx [ ] Non Rx
	Reason for use:			Date Started: Month / Year	Formulation Code:	
4.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N [X] Rx [ ] Non Rx
	Reason for use:			Date Started: Month / Year	Formulation Code:	
5.				____ D W M	[ ] Y [ ] N	[ ] Y [ ] N [X] Rx [ ] Non Rx
	Reason for use:			Date Started: Month / Year	Formulation Code:	

Page Link #

Annotated, 12/12/2001 pjm
HABC Prox Home Visit, Version 1.0, 6/12/00 pjm

Health ABC

PROXY CONTACT HOME VISIT
MEDICATION INVENTORY FORM -- Page B

Section B Prescription Medication -- Continued

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
6.	MIFNAME	MIF STRE N	MIF UNIT	MIFDWM ____ D W M	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	X Rx 1 MIFRX 0 Non Rx
7.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
8.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
9.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
10.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
11.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx
12.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	X Rx ☐ Non Rx

☐ Continued on MIF Supplement

Formulation Codes
0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Page Link # ☐

Health ABC

PROXY CONTACT HOME VISIT
MEDICATION INVENTORY FORM -- Page C

Section C Over-the-counter Medications and Supplements

Copy the name of the over-the-counter medicine, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1.	MIFNAME	MIF STRE N	MIF UNIT	MIFDWM ____ D W M	MIFPRN 1 Y 0 N	1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	1 Rx MIFRX X0 Non Rx
2.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx X Non Rx
3.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx X Non Rx
4.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx X Non Rx
5.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx X Non Rx
6.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx X Non Rx
7.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month / Year	Formulation Code:	☐ Rx X Non Rx

Health ABC

PROXY CONTACT HOME VISIT
MEDICATION INVENTORY FORM -- Page D

Section C Over-the-counter Medications and Supplements -- Continued

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
8.	MIFNAME	MIF STRE N	MIF UNIT	MIFDWM ____ D W M	MIFPRN 1 Y 0 N	MIFSEEN 1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORMX	1 Rx X Non Rx MIFRX
9.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx X Non Rx
10.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx X Non Rx
11.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx X Non Rx
12.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx X Non Rx
13.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx X Non Rx
14.				____ D W M	☐ Y ☐ N	☐ Y ☐ N
	Reason for use:			Date Started: Month Year	Formulation Code:	☐ Rx X Non Rx

☐ Continued on MIF Supplement

Formulation Codes
0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=topical cream, lotion, or ointment, 5=other liquid, 6=ophthalmic, 7=missing, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 99=other

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		Month / Day / Year	
MAID/MIFIF	MAACROS	MIFDATE/MADATE	MASTAFF

PROXY CONTACT HOME VISIT

MEDICATION INVENTORY FORM SUPPLEMENT

Prescription and Over-the-counter Medications and Supplements

Copy the name of the prescription or over-the-counter medicine, the strength in milligrams (mg) or other units, and the total number of doses taken per day, week or month. Indicate whether the medication is taken on an "as needed" basis, and whether or not the container was actually seen. In addition, record reason for use, date started, and formulation code.

	Medication Name (Generic Name or Trade Name)	Strength	Units	Indicate Number Used & Circle Day, Week or Month	PRN? Check "X": Yes or No	Container Seen? Check "X": Yes or No
1S.	MIFNAME	MIF STRE N	MIF UNIT	MIFDWM ____ D W M	1 Y 0 N	1 Y 0 N
	Reason for use: MIFREAS			Date Started: MIFMONTH / MIFYEAR Month Year	Formulation Code: MIFFORM	1 Rx 0 Non Rx MIFRX
2S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: / Month Year	Formulation Code:	Rx Non Rx
3S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: / Month Year	Formulation Code:	Rx Non Rx
4S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: / Month Year	Formulation Code:	Rx Non Rx
5S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: / Month Year	Formulation Code:	Rx Non Rx
6S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: / Month Year	Formulation Code:	Rx Non Rx
7S.				____ D W M	Y N	Y N
	Reason for use:			Date Started: / Month Year	Formulation Code:	Rx Non Rx

Health ABC

HABC Enrollment ID #	Acrostic
H	
YCID	YCACROS

PROXY CONTACT HOME VISIT WORKBOOK

Year of annual contact: ③ Year 03 ⑥ Year 06
④ Year 04 ⑦ Year 07 **YCVISIT**
⑤ Year 05 ⑧ Other ***(Please specify:)*** _____

WEIGHT AND RADIAL PULSE

WEIGHT

YCWT ___.___ ① lbs ② kg **YCLBSKG** **YCSTFID1** Staff ID#

RADIAL PULSE

YCSTFID2 Staff ID#

Measurement 1 **YCPLSSM1** ___ beats per 30 seconds

Measurement 2 **YCPLSMS2** ___ beats per 30 seconds

YCLINK

Annotated: 6/12/00 pjm
HABC Prox Home Visit,
Version 1.0, 6/12/00 pjm

Draft

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

YCSTFID3

PROXY CONTACT HOME VISIT WORKBOOK
BLOOD PRESSURE

❶ Cuff Size **YCOCUF** ④ Small ① Regular ② Large ③ Thigh

❷ Arm Used **YCARMRL** ① Right ② Left → ***Please explain why right arm was not used:*** _____ _____

(Examiner Note: Refer to Data from Prior Visits Report.)

Pulse Obliteration Level

❸ Palpated Systolic **YCPOPS** ☐☐☐ mmHg

Add 30*

❹ Maximal Inflation Level (MIL) ☐☐☐ † mmHg **YCPOMX**

* ***Add +30 to Palpated Systolic to obtain Maximal Inflation Level.***

† ***If MIL is ≥ 300 mmHg, repeat the MIL. If MIL is still ≥ 300 mmHg, terminate blood pressure measurements.***

❺ Was blood pressure measurement terminated because MIL was ≥ 300 mmHg after second reading?
YCBPYN ① Yes ⓪ No

Sitting Blood Pressure Measurement #1

❻ Systolic **YCSYS** ☐☐☐ mmHg

❼ Diastolic **YCDIA** ☐☐☐ mmHg

Comments (required for missing or unusual values): _____ _____ _____

Sitting Blood Pressure Measurement #2

❽ Systolic **YCSY2** ☐☐☐ mmHg

❾ Diastolic **YCDIA2** ☐☐☐ mmHg

Comments (required for missing or unusual values): _____ _____ _____

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

YCSTFID4

PROXY CONTACT HOME VISIT WORKBOOK

GRIP STRENGTH (Hand-Held Dynamometry)

Exclusion Criterion:

❶ Have you had any surgery on your hands or wrists in the past three months?

YCWRST1 ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

Which hand?

YCWRTRL

① Right → Do NOT test right.

② Left → Do NOT test left.

③ Both right & left → Do NOT test either hand. Go to Questions #4 and #5 and mark "Unable to test/exclusion."

⑧ Don't know/ Didn't understand

---

❷ Has any pain or arthritis in your right hand gotten worse recently?

YCARWRSR ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

Will the pain keep you from squeezing as hard as you can?

YCPSQ1 ① Yes ⓪ No ⑧ Don't know/ Didn't understand

---

❸ Has any pain or arthritis in your left hand gotten worse recently?

YCARWRSL ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

Will the pain keep you from squeezing as hard as you can?

YCPSQ2 ① Yes ⓪ No ⑧ Don't know/ Didn't understand

PROXY CONTACT HOME VISIT WORKBOOK

GRIP STRENGTH (Hand-Held Dynamometry)

Script: "I'd like you to take your right/left arm, rest it on the table, and bend your elbow. Grip the two bars in your hand, like this. Please slowly squeeze the bars as hard as you can."

Examiner Note: Hand the dynamometer to the participant. Adjust if needed.

Script: "Now try it once just to get the feel of it. For this practice, just squeeze gently. It won't feel like the bars are moving, but your strength will be recorded. Are the bars the right distance apart for a comfortable grip?"

Examiner Note: Show dial to participant.

Script: "We'll do this two times. This time it counts, so when I say squeeze, squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

---

4 Right Hand ① Unable to test/exclusion/didn't understand **YCNOTST**

Trial 1 ☐☐ kg **YCRTR1** ⑦ Refused ⑨ Unable to complete **YCRRUC1**

Examiner Note: Wait 15-20 seconds before second trial.

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Trial 2 ☐☐ kg **YCRTR2** ⑦ Refused ⑨ Unable to complete **YCRRUC2**

Repeat the procedure on the left side.

---

5 Left Hand ① Unable to test/exclusion/didn't understand **YCLNTST**

Script: "Now we'll test your left side. When I say squeeze, squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Trial 1 ☐☐ kg **YCLTR1** ⑦ Refused ⑨ Unable to complete **YCLRUC1**

Examiner Note: Wait 15-20 seconds before second trial.

"Now, one more time. Squeeze as hard as you can. Ready. Squeeze! Squeeze! Squeeze! Now, STOP."

Trial 2 ☐☐ kg **YCLTR2** ⑦ Refused ⑨ Unable to complete **YCLRUC2**

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

YCSTFID5

PROXY CONTACT HOME VISIT WORKBOOK
CHAIR STANDS

SINGLE CHAIR STAND

Describe: "This is a test of strength in your legs in which you stand up without using your arms."

Demonstrate and say: "Fold your arms across your chest, like this, and stand when I say GO, keeping your arms in this position. OK?"

Test: "Ready, Go!"

YCSCS

③ No suitable chair	Go to Standing Balance.
⑦ Participant refused/didn't understand	Go to Standing Balance.
⑨ Not attempted, unable	Go to Standing Balance.
⓪ Attempted, unable to stand	Go to Standing Balance.
① Rises using arms	Go to Standing Balance.
② Stands without using arms	Go to Repeated Chair Stands.

REPEATED CHAIR STANDS

Describe: "This time, I want you to stand up five times as quickly as you can keeping your arms folded across your chest."

Demonstrate and say: "When you stand up, come to a full standing position each time, and when you sit down, sit all the way down each time. I will demonstrate two chair stands to show you how it is done."

Examiner Note: Rise two times as quickly as you can, counting as you sit down each time.

Test: "When I say 'Go' stand five times in a row, as quickly as you can, without stopping. Stand up all the way, and sit all the way down each time.

Ready, Go!"

Examiner Note: Start timing as soon as you say "Go." Count: "1, 2, 3, 4, 5" as the participant sits down each time.

⑦ Participant refused/didn't understand **YCRCS**

⑨ Not attempted, unable

① Attempted, unable to complete 5 stands without using arms → **YCCOMP** ☐ Number completed without using arms

② Completes 5 stands without using arms → ☐☐.☐☐ **YCSEC** Seconds to complete

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

YCSTFID6

PROXY CONTACT HOME VISIT WORKBOOK
STANDING BALANCE

INTRODUCTION: "I'm going to ask you to stand in several different positions that test your balance. I'll demonstrate each position and then ask you to try to stand in each position for 30 seconds. I'll be near you to provide support, and the wall is close enough to prevent you from falling if you lose your balance. Do you have any questions?"

SEMI-TANDEM STAND

Describe: "First I would like you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 30 seconds. Please watch while I demonstrate."

Demonstrate and say: "You may put either foot in front, whichever is more comfortable. You can use your arms and body to maintain your balance. Try to hold your feet in position until I say stop. If you lose your balance, take a step like this."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Examiner Note: Start timing when the participant lets go. If the participant does not hold onto your arm, start timing when they are in position.

YCSTS

⑦ Participant refused/didn't understand → Go to 4-meter walk.

⑨ Not attempted, unable → Go to 4-meter walk.

① Unable to attain position or cannot hold for at least one second → STOP Semi-Tandem Stand. Go to 4-meter walk.

② Holds position between 1 and 29 seconds → **YCSTSTM** ___ . ___ seconds. Go to Tandem Stand.

③ Holds position for 30 seconds → Go to Tandem Stand.

TANDEM STAND

Describe: "Now I would like you to try to stand with the heel of one foot in front of and touching the toes of the other foot. I'll demonstrate."

Demonstrate and say: "Again, you may use your arms and body to maintain your balance. Try to hold your feet in position until I say stop. If you lose your balance, take a step, like this."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Trial 1:

YCTS1

⑦ Participant refused/didn't understand → Go to One-Leg Stand.

⑨ Not attempted, unable → Go to One-Leg Stand.

① Unable to attain position or cannot hold for at least one second → Go to Trial 2.

② Holds position between 1 and 29 seconds → **YCTSTM** ___ . ___ seconds. Go to Trial 2.

③ Holds position for 30 seconds → Go to One-Leg Stand.

TANDEM STAND

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

YCTS2

⑦ Participant refused/didn't understand → Go to One-Leg Stand.

⑨ Not attempted, unable → Go to One-Leg Stand.

① Unable to attain position or cannot hold for at least one second → Go to One-Leg Stand.

② Holds position between 1 and 29 seconds → YCTS2TM ___.___ seconds. Go to One-Leg Stand.

③ Holds position for 30 seconds → Go to One-Leg Stand.

ONE-LEG STAND

Describe: "For the last position, I would like you to try to stand on one leg for 30 seconds. You may stand on either leg, whichever is more comfortable. I'll demonstrate."

Demonstrate and say: "Try to hold your foot up until I say stop. If you lose your balance put your foot down."

Examiner Note: Allow the participant to hold onto your arm to get balanced.

Test: "Hold onto my arm while you get in position. When you are ready, let go."

Trial 1:

YCTR1

⑦ Participant refused/didn't understand → Go to 4-meter walk.

⑨ Not attempted, unable → Go to 4-meter walk.

① Unable to attain position or cannot hold for at least one second → Go to Trial 2.

② Holds position between 1 and 29 seconds → YCTR1TM ___.___ seconds. Go to Trial 2.

③ Holds position for 30 seconds → Go to 4-meter walk.

Perform a second trial: "Now, let's do the same thing one more time."

Trial 2:

YCTR2

⑦ Participant refused/didn't understand → Go to 4-meter walk.

⑨ Not attempted, unable → Go to 4-meter walk.

① Unable to attain position or cannot hold for at least one second → Go to 4-meter walk.

② Holds position between 1 and 29 seconds → YCTR2TM ___.___ seconds. Go to 4-meter walk.

③ Holds position for 30 seconds → Go to 4-meter walk.

PROXY CONTACT HOME VISIT WORKBOOK
4-METER WALK

Examiner Note: Measure out 4 meters for the walk. If a 4-meter space is not available, measure 3 meters.

❶ Which walk was set up?

YC4MW ① 4-meter ② 3-meter ⓪ None: No 3-meter space was available → Go to Knee Crepitus.

USUAL PACE WALK

❷ *Describe the 4-meter walk and demonstrate how to walk past the tape.*

Script: "This is a three part walking test. The first and second parts test your usual walking speed. Please walk past the tape, then stop. Now, wait until I say 'Go.' For the first part of this test, I want you to walk at your usual walking pace. Any questions?"

❸ *To start the test, say,*

Script: "Ready, Go."

❹ *Start timing with the first footfall over the start line (participant's foot touches the floor). Stop timing with the participant's first footfall over the finish line at 4-meters (or 3-meters). You will need to walk a few steps behind the participant. Start timing with the first footfall over the starting line (participant's foot touches the floor.)*

Time on stopwatch: [ ][ ] . [ ][ ] **YC4MWTM1** → ***Examiner Note: If greater than 30 seconds mark as "Attempted, but unable to complete." Do not record time.***

Second Hundredths/Sec

⑦ Participant refused/didn't understand → Go to Knee Crepitus.

YC4MW1 ⑨ Not attempted, unable → Go to Knee Crepitus.

① Attempted, but unable to complete → Go to Knee Crepitus.

❺ *Reset the stopwatch and have the participant repeat the usual-pace walk.*

Script: "For the next part of the test, I want you to walk again at your usual walking pace. When you walk past the tape please stop. Ready, Go."

Time on stopwatch: [ ][ ] . [ ][ ] **YC4MWTM2** → ***Examiner Note: If greater than 30 seconds mark as "Attempted, but unable to complete." Do not record time.***

Second Hundredths/Sec

⑦ Participant refused/didn't understand → Go to Knee Crepitus.

YC4MW2 ⑨ Not attempted, unable → Go to Knee Crepitus.

① Attempted, but unable to complete → Go to Knee Crepitus.

⑥ RAPID WALK

Reset the stopwatch and instruct the participant to walk as quickly as they can for the third portion of the test.
Script: "When I say go, I want you to walk as fast as you can. Ready, Go."

Time on stopwatch: ☐☐ . ☐☐ **YC4MWTM3**
Second Hundredths/Sec

⑦ Participant refused/didn't understand → Go to Knee Crepitus.

YC4MW3 ⑨ Not attempted, unable → Go to Knee Crepitus.

① Attempted, but unable to complete → Go to Knee Crepitus.

---

⑦ Was the participant using a walking aid, such as a cane or walker?
① Yes ⓪ No **YCWLKAID**

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

YCSTFID8

PROXY CONTACT HOME VISIT WORKBOOK
KNEE CREPITUS

Examiner Note: If participant has an artificial leg or total knee replacement, do not test for knee crepitus on that side. Crepitus is defined as palpable continuous noise or grinding sensation (series of small clicks, pops, or grinding similar to sandpaper scratching sensation). Place your palm over the participant's patella. Ask the participant to actively move their leg to a full extended position (zero degrees) twice, then rest a moment, then twice more.

❶ Have you had a knee replacement in your right knee?

YCKNREPR ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

→ Do NOT examine right knee. Go to Question #3.

❷ Is there crepitus in the right knee?

⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
YCAJCRPR ③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason (e.g. artificial leg)

YCRN2EX Consensus with 2nd examiner
⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason

2nd examiner Staff ID#: **YC2EXID1**

❸ Have you had a knee replacement in your left knee?

① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused **YCKNREPL**

→ Do NOT examine left knee.

❹ Is there crepitus in the left knee?

⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
YCAJCRPL ③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason (e.g. artificial leg)

YCLN2EX Consensus with 2nd examiner
⓪ Absent on all trials
① Present on just one trial
② Present on two or three trials
③ Present all four trials
④ Uncertain
⑤ Unable to examine due to knee pain
⑥ Unable to examine for other reason

2nd examiner Staff ID#: **YC2EXID2**

Examiner Note: If the participant cannot fully extend their leg, assist them by holding the leg at the ankle and pumping through a full range of motion.

PROXY CONTACT HOME VISIT WORKBOOK
ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

1 Have you ever had knee surgery on either leg where all or part of the joint was replaced?

YCKNRP2 (1) Yes (0) No (8) Don't know/ Didn't understand (7) Refused

→ Which leg?

YCKRLB3 (1) Right leg → Do NOT test right leg.

(2) Left leg → Do NOT test left leg.

(3) Both legs → Do NOT test either leg. Go to Question #10.

2 Has the participant ever had the isometric chair measurement?
(Examiner Note: Refer to the Data from Prior Visits Report.)

YCISO (1) Yes →

Which leg was tested during the most recent isometric chair measurement?
(Examiner Note: Refer to the Data from Prior Visits Report.)

YCISOLEG (1) Right leg → Test right leg unless contraindicated.

(2) Left leg → Test left leg unless contraindicated.

(0) No →

Has the participant ever had the Kin-Com exam?

YCKC (1) Yes →

Which leg was tested during the most recent Kin-Com exam?
(Examiner Note: Refer to the Data from Prior Visits Report.)

YCKCLEG (1) Right leg → Test right leg unless contraindicated.

(2) Left leg → Test left leg unless contraindicated.

(0) No → Test right leg unless contraindicated.

❸ What is the seat height?

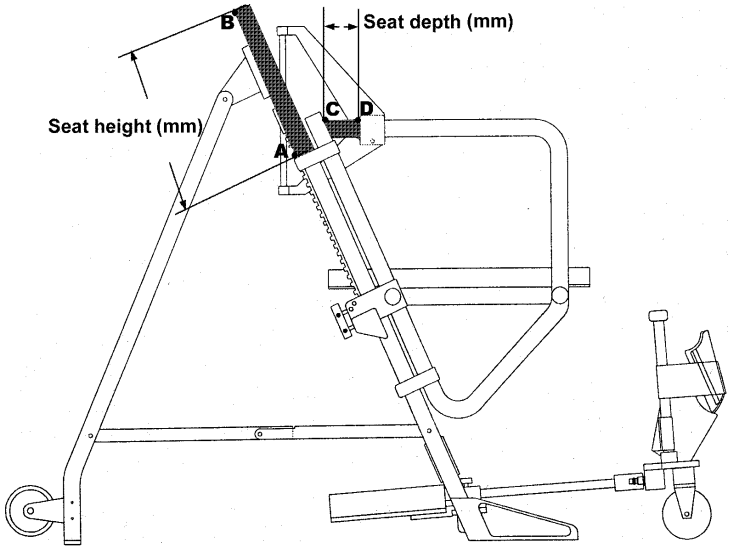
(Examiner Note: Record the seat height by measuring the distance between point "A" and "B" as noted below. Use a ruler marked in millimeters.)

YCSEATHT ☐☐☐ mm

❹ What is the seat depth?

(Examiner Note: Record the seat depth by measuring the distance between point "C" and "D" as noted below. Use a ruler marked in millimeters. Be sure that the depth is exactly the same measurement on both sides of the chair.)

YCSEATDP ☐☐☐ mm



❺ What is the length of the lower leg to be tested? **YCLEG1** ☐.☐☐ meters

❻ Which leg was tested?

YCRL4 ① Right leg ② Left leg ③ Test not performed → Go to Question #10.

Trial	Maximum Torque (Nm)	Max Rate Torque (Nm/sec)	Reaction Time (msec)	Time to 50% MVTD (msec)	Did participant have knee pain?
1.	☐☐☐.☐ YCMT1A	☐☐☐☐.☐ YCMRT1A	☐☐☐☐ YCRT1A	☐☐☐☐ YCMVTD1A	YCKP1A ① Yes ⓪ No → Test other leg. Go to Question #7.
2.	☐☐☐.☐ YCMT2A	☐☐☐☐.☐ YCMRT2A	☐☐☐☐ YCRT2A	☐☐☐☐ YCMVTD2A	YCKP2A ① Yes ⓪ No → Test other leg. Go to Question #7.
3.	☐☐☐.☐ YCMT3A	☐☐☐☐.☐ YCMRT3A	☐☐☐☐ YCRT3A	☐☐☐☐ YCMVTD3A	Test complete. Go to Question #9.

PROXY CONTACT HOME VISIT WORKBOOK
ISOMETRIC STRENGTH (ISOMETRIC CHAIR)

7 What is the length of the lower leg?
(Examiner Note: Only test the other leg if three trials were not possible on the first leg. This should be the length of the other leg to be tested.)

YCLEG2 ___.___ meters

8 Which other leg is being tested?

YCRL5 ① Right leg ② Left leg ③ Test not performed → Go to Question #10.

Trial	Maximum Torque (Nm)	Max Rate Torque (Nm/sec)	Reaction Time (msec)	Time to 50% MVTD (msec)	Did participant have knee pain?
1.	___.___ YCMT1B	___.___ YCMRT1B	YCRT1B	YCMVTD1B	YCKP1B ① Yes ⓪ No → STOP. Go to Question #9.
2.	___.___ YCMT2B	___.___ YCMRT2B	YCRT2B	YCMVTD2B	YCKP2B ① Yes ⓪ No → STOP. Go to Question #9.
3.	___.___ YCMT3B	___.___ YCMRT3B	YCRT3B	YCMVTD3B	Test complete. Go to Question #9.

9 What size connecting rod was used?

YCROD ① Small ② Medium ③ Large

10 Was the participant able to complete the isometric strength test?

YCISOTST ① Yes ⓪ No

Why not?
(Examiner Note: Mark <u>all</u> that apply.)

- **YCKCBKR3** ① Not eligible: bilateral knee replacement
- **YCKCPN3** ① Knee pain
- **YCKCEQ3** ① Equipment problems
- **YCKCREF3** ① Participant refused/didn't understand
- **YCKCFAT3** ① Participant fatigue
- **YCKCOTH3** ① Other ***(Please specify:*** _____)

Health ABC

HABC Enrollment ID #	Acrostic	Staff ID #
H		

YCSTID10

PROXY CONTACT HOME VISIT WORKBOOK
ULTRASOUND

❶ Have you broken any bones in your legs, ankles, or feet in the past 12 months?
(Examiner Note: Do not include isolated toe fractures.)

YCBKFEET ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

Scan same foot as most recent ultrasound measurement.
If no previous ultrasound measurement scan right foot.

Which side? **YCBKRLB**

① Right side → Scan left foot.
② Left side → Scan right foot.
③ Both right & left side → Scan same foot as most recent ultrasound measurement.
⑧ Don't know/Didn't understand → Scan same foot as most recent ultrasound measurement.

❷ Sahara serial #: **YCSERIAL**

❸ Which foot was scanned? **YCBUSCAN**

① Right ② Left ③ Scan not attempted ④ Scan not completed

Why was the left foot scanned? **YCBULEFT**
① Fracture
② Permanent weakness on right side
③ Hardware
④ Other
(Please specify: _____)

Why wasn't the scan attempted? **YCBUCOMP**
① Participant refused
② Equipment problem
③ Foot too big/edema/deformity
④ Other
(Please specify: _____)

Why wasn't the scan completed? **YCBUNOSC**
① Out of range reading
② Invalid measurement
③ Other
(Please specify: _____)

❹ Measurement #1:

QUI YCBUQUI1 . units

BUA YCBUBUA1 . units → Did BUA result have an asterisk? ① Yes ⓪ No YCBUAST1

SOS YCBUSOS1 . m/s

Measurement #2:

QUI YCBUQUI2 . units

BUA YCBUBUA2 . units → Did BUA result have an asterisk? ① Yes ⓪ No YCBUAST2

SOS YCBUSOS2 . m/s

❺ What is the difference between BUA measurement #1 and BUA measurement #2?

YCBUDIF1 . units

a. Was the difference between BUA measurement #1 and BUA measurement #2 ≥ 10 units?

YCBUDIF2 ① Yes ⓪ No

↓

Repeat scan and record results in section #6 below.

b. Did both BUA measurement #1 and BUA measurement #2 have an asterisk?

YCBU2AST ① Yes ⓪ No

↓

Repeat scan and record results in section #6 below.

❻

QUI YCBUQUI3 . units

BUA YCBUBUA3 . units → Did BUA result have an asterisk? ① Yes ⓪ No YCBUAST3

SOS YCBUSOS3 . m/s

PROXY CONTACT HOME VISIT WORKBOOK
BONE DENSITY (DXA) SCAN

❶ Do you have breast implants?

YCBI ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

- Flag scan for review by DXA Reading Center.
- Indicate in the table below whether breast implant is in "Left ribs" or "Right ribs" subregion.

❷ Do you have any metal objects in your body, such as a pacemaker, staples, screws, plates, etc.?

YCMO ① Yes ⓪ No ⑧ Don't know/ Didn't understand ⑦ Refused

a. Flag scan for review by DXA Reading Center.

b. Indicate in the table the location of joint replacement, hardware or other artifacts (sub regions are those defined by the whole body scan analysis.)

Sub	Hardware	Other Artifacts
Head	①	② YCHEAD
Left arm	①	② YCLA
Right arm	①	② YCRA
Left ribs	①	② YCLR
Right ribs	①	② YCRR
Thoracic spine	①	② YCTS
Lumbar spine	①	② YCLS
Pelvis	①	② YCPEL
Left leg	①	② YCLL
Right leg	①	② YCRL

❸ Have you had any of the following tests within the past ten days?

	Yes	No	Don't know/ Didn't understand
a. Barium enema	① *	⓪	⑧ **YCBE**
b. Upper GI X-ray series	① *	⓪	⑧ **YCUGI**
c. Lower GI X-ray series	① *	⓪	⑧ **YCLGI**
d. Nuclear medicine scan	① *	⓪	⑧ **YCNUKE**
e. Other tests using contrast ("dye") or radioactive materials	① *	⓪	⑧ **YCOTH2**

(*Examiner Note: If "Yes" to any, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.)

❹ Was a bone density measurement obtained for...?

a. Whole Body

① Yes ⓪ No **YCWB**

Last 2 characters of scan ID #: **YCSCAN1** ☐☐

Date of scan: ☐☐ / ☐☐ / 2 0 0 ☐

Month Day Year **YCSCDTE1**

b. Hip

① Yes ⓪ No **YCHIP**

Last 2 characters of scan ID #: **YCSCAN2** ☐☐

Date of scan: ☐☐ / ☐☐ / 2 0 0 ☐

Month Day Year **YCSCDTE2**

Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
H		/ /	
BJID	BJACROS	Month Day Year BJDATE	BJSTFID

MISSEDFOLLOW-UPCONTACT

Complete this form for each regularly scheduled follow-up clinic visit or telephone contact that has been missed and cannot be made-up.

1 Type of Follow-up Contact Missed

BJTYPE

① Annual Clinic Visit →

Which visit? BJVISIT

② Year 02
③ Year 03
④ Year 04
⑤ Year 05
⑥ Year 06
⑦ Year 07

BJVISIT

② Semi-Annual Phone Interview →

Which contact? BJCONTAC

① 6-mo
② 18-mo
③ 30-mo
④ 42-mo
⑤ 54-mo
⑥ 66-mo
⑦ 78-mo

BJCONTAC

2 Reason Follow-up Contact Missed BJREASON

Please check the primary reason for the missed follow-up visit or telephone contact.
Check **only one** reason.

① Illness/health problem(s)
② Hearing difficulties
③ Cognitive difficulties
④ In nursing home/long-term care facility
⑤ Too busy; time and/or work conflict
⑥ Caregiving responsibilities
⑦ Physician's advice
⑧ Family member's advice
⑨ Clinic too far/travel time
⑩ Moved out of area
⑪ Travelling/on vacation
⑫ Personal problem(s)
⑬ Unable to contact/unable to locate
⑭ Refused to give reason
⑮ Modified follow-up regimen (e.g. will only agree to one contact per year)
⑱ Withdrew from study/withdrew informed consent
⑯ Deceased
⑰ Other *(Please specify:* _____ *)*

3 Comments

_____

_____

_____

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Health ABC

HABC Enrollment ID #	Acrostic	Date Form Completed	Staff ID #
BLID	BLACROS	Month / Day / Year BLDATE	BLSTFID

SEMI-ANNUAL TELEPHONE CONTACT

Telephone contact: **BLCONTAC**
③ 30-mo ④ 42-mo ⑤ 54-mo ⑥ 66-mo ⑦ 78-mo ⑧ Other *(Please specify)* _____

Date of last contact: Month / Day / Year **BLDTCON**

I would like to ask you some questions that we asked you about 6 months ago, on (date of last contact). The reason for asking them again is to find out how you've been doing during the past six months.

1. In general, how would you say your health is? Would you say it is. . .
(Interviewer Note: Read response options.)

BLHSTAT
① Excellent
② Very good
③ Good
④ Fair
⑤ Poor
⑧ Don't know
⑦ Refused

2. Since we last spoke to you about 6 months ago, did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.

BLBED12 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

About how many days did you stay in bed all or most of the day because of an illness or injury? Please include days that you were a patient in a hospital.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLBEDDAY ___ days

3. Since we last spoke to you about 6 months ago, did you cut down on the things you usually do, such as going to work or working around the house, because of an illness or injury? Please include days in bed.

BLCUT12 ① Yes ⓪ No ⑧ Don't know ⑦ Refused

How many days did you cut down on the things you usually do because of illness or injury? Please include days in bed.
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLCUTDAY ___ days

Page Link # **BLLINK**

Re-Annotated: 12/20/2001 pjm
Version 2.0, 01/13/2000 pjm
Draft

SEMI-ANNUAL TELEPHONE CONTACT

4. Since we last spoke to you about 6 months ago, did you stay overnight as a patient in a nursing home or rehabilitation center?

BLMCNH (1) Yes (0) No (8) Don't know (7) Refused

5. Since we last spoke to you about 6 months ago, did you receive care at home from a visiting nurse, home health aide, or nurse's aide?

BLMCVN (1) Yes (0) No (8) Don't know (7) Refused

6. Since we last spoke to you about 6 months ago, have you had a cold or flu that was bad enough to keep you in bed for all or most of the day?

BLFLU (1) Yes (0) No (8) Don't know (7) Refused

a. Did you take your temperature?

Analyst Note: The wording was later changed to: "Was your temperature taken?"

BLTEMP (1) Yes (0) No (8) Don't know

Go to Question #6b

Was your temperature 100° or higher?

(1) Yes* (0) No (8) Don't know **BLTEMPHI**

b. Did a doctor or nurse tell you that you had the flu or a fever?

BLFLUDR (1) Yes (0) No (8) Don't know

c. Did you have body aches, chills, or muscle weakness that lasted two or more days?

BLACHES (1) Yes (0) No (8) Don't know

d. Were you hospitalized overnight for pneumonia or bronchitis following the illness?

BLPNEU (1) Yes (0) No (8) Don't know

* ***Interviewer Note: Please complete Substudy Workbook.***

Page Link #

Version 2.0, 01/13/2000 pjm

Draft

7. Because of a health or physical problem, do you have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks? ***(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk because of a health or physical problem, check "Yes." If the participant doesn't walk for other reasons, check "Don't do.")***

BLDWQMYN (1) Yes (0) No (8) Don't know (7) Refused (9) Don't do

(0) (8) (7) → Go to Question #7c

(9) → Go to Question #8

a. How much difficulty do you have? ***(Interviewer Note: Read response options.)***

BLDWQMDF
- (1) A little difficulty
- (2) Some difficulty
- (3) A lot of difficulty
- (4) Or are you unable to do it?
- (8) Don't know

b. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?
(Interviewer Note: If "some other reason," probe for response. Do NOT read response options. Mark only ONE answer.)

BLMNRS
- (1) Arthritis
- (2) Back pain
- (3) Balance problems/unsteadiness on feet
- (4) Cancer
- (5) Chest pain/discomfort
- (6) Circulatory problems
- (7) Diabetes
- (8) Fatigue/tiredness (no specific disease)
- (9) Fall
- (10) Heart disease (including angina, congestive heart failure, etc)
- (11) High blood pressure/hypertension
- (12) Hip fracture
- (13) Injury (Please specify: _____)
- (14) Joint pain
- (15) Lung disease (asthma, chronic bronchitis, emphysema, etc)
- (16) Old age (no mention of a specific condition)
- (17) Osteoporosis
- (18) Shortness of breath
- (19) Stroke
- (1) Other symptom (*Please specify:* _____) **BLMNRS4**
- (2) Multiple conditions/symptoms given; unable to determine MAIN reason
- (8) Don't know

Go to Question #8

Page Link #

7c. How easy is it for you to walk a quarter of a mile?
(Interviewer Note: Read response options.)

BLDWQMEZ
1. Very easy
2. Somewhat easy
3. Or not that easy
8. Don't know/Don't do

7d. Do you get tired when you walk a quarter of a mile?

BLDWQMT2
1. Yes
0. No
8. Don't know/Don't do

7e. Because of a health or physical problem, do you have any difficulty walking a distance of one mile, that is about 8 to 12 blocks?

BLDW1MYN
1. Yes → Go to Question #8
0. No → Go to Question #7f
8. Don't know/Don't do → Go to Question #7f

7f. How easy is it for you to walk one mile?
(Interviewer Note: Read response options.)

BLDW1MEZ
1. Very easy
2. Somewhat easy
3. Or not that easy
8. Don't know/Don't do

Page Link #

8. Because of a health or physical problem, do you have any difficulty walking up 10 steps, that is about 1 flight, without resting? ***(Interviewer Note: If the participant responds "Don't do," probe to determine whether this is because of a health or physical problem. If the participant doesn't walk up 10 steps because of a health or physical problem, check "Yes." If the participant doesn't walk up steps for other reasons, such as there are simply no steps in the area, check "Don't do.")***

BLDW10YN (1) Yes (0) No (8) Don't know (7) Refused (9) Don't do

(0) (8) (7) → Go to Question #8c

(9) → Go to Question #9

a. How much difficulty do you have?
(Interviewer Note: Read response options.)

(1) A little difficulty
(2) Some difficulty
BLDIF (3) A lot of difficulty
(4) Or are you unable to do it?
(8) Don't know

b. What is the main reason that you have difficulty? Is it because of arthritis, shortness of breath, heart disease, or some other reason?
(Interviewer Note: If "some other reason," probe for response. Do NOT read response options. Mark only ONE answer.)

BLMNRS2

(1) Arthritis
(2) Back pain
(3) Balance problems/unsteadiness on feet
(4) Cancer
(5) Chest pain/discomfort
(6) Circulatory problems
(7) Diabetes
(8) Fatigue/tiredness (no specific disease)
(9) Fall
(10) Heart disease (including angina, congestive heart failure, etc)
(11) High blood pressure/hypertension
(12) Hip fracture
(13) Injury (Please specify: _____)
(14) Joint pain
(15) Lung disease (asthma, chronic bronchitis, emphysema, etc)
(16) Old age (no mention of a specific condition)
(17) Osteoporosis
(18) Shortness of breath
(19) Stroke
(1) Other symptom (Please specify: _____) **BLMNRS3**
(2) Multiple conditions/symptoms given; unable to determine MAIN reason
(8) Don't know

Go to Question #9

Page Link #

8c. How easy is it for you to walk up 10 steps without resting?
(Interviewer Note: Read response options.)

BLDW10EZ
1. Very easy
2. Somewhat easy
3. Or not that easy
8. Don't know/Don't do

8d. Do you get tired when you walk up 10 steps without resting?

BLDW10WX
1. Yes
0. No
8. Don't know/Don't do

8e. Because of a health or physical problem, do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

BLDW20YN
1. Yes → Go to Question #9
0. No → Go to Question #8f
8. Don't know/Don't do → Go to Question #8f

8f. How easy is it for you to walk up 20 steps without resting?
(Interviewer Note: Read response options.)

BLDW20EZ
1. Very easy
2. Somewhat easy
3. Or not that easy
8. Don't know/Don't do

9. In general, would you say that your appetite or desire to eat has been. . . ?
(Interviewer Note: Read response options.)

BLAPPET

① Very good
② Good
③ Moderate
④ Poor
⑤ Very poor
⑧ Don't know
⑦ Refused

10. How much do you currently weigh?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLWTLBS ☐☐☐ pounds ⑧ Don't know/don't remember ⑦ Refused **BLLBS2**

11. Since we last spoke to you about 6 months ago, has your weight changed by 5 or more pounds?

BLCHN5LB ① Yes ⓪ No ⑧ Don't know ⑦ Refused

a. Did you gain or lose weight?

BLGNLS ① Gain ② Lose ⑧ Don't know/don't remember

b. How many pounds did you gain/lose in the past 6 months?
(Interviewer Note: If necessary, probe - "If you are unsure, please make your best guess.")

BLHOW6 ☐☐ pounds ⑧ Don't know/don't remember ⑦ Refused **BLHOW6DN**

c. Were you trying to gain/lose weight?

BLTRGNLS ① Yes ⓪ No ⑧ Don't know

12. At the present time, are you trying to lose weight?

BLTRYLOS ① Yes ⓪ No ⑧ Don't know ⑦ Refused

Page Link # ☐

Version 2.0, 01/13/2000 pjm

Draft

SEMI-ANNUAL TELEPHONE CONTACT

Now I'm going to ask you about any medical problems you might have had since we last spoke to you about 6 months ago, which was on ☐☐ / ☐☐ / ☐☐
Month Day Year

13. Since we last spoke to you about 6 months ago, has a doctor told you that you had a heart attack, angina, or chest pain due to heart disease?

BLHCHAMI (1) Yes (0) No (8) Don't know (7) Refused

Were you hospitalized overnight for this problem?

BLHOSMI (1) Yes (0) No → Go to Question #14

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization.
Record reference #'s below:

a. ☐☐☐☐☐ **BLREF13A**
b. ☐☐☐☐☐ **BLREF13B**
c. ☐☐☐☐☐ **BLREF13C**

14. Since we last spoke to you about 6 months ago, has a doctor told you that you had a stroke, mini-stroke, or TIA ?

BLHCCVA (1) Yes (0) No (8) Don't know (7) Refused

Were you hospitalized overnight for this problem?

BLHOSMI2 (1) Yes (0) No → Go to Question #15

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization.
Record reference #'s below:

a. ☐☐☐☐☐ **BLREF14A**
b. ☐☐☐☐☐ **BLREF14B**
c. ☐☐☐☐☐ **BLREF14C**

15. Since we last spoke to you about 6 months ago, has a doctor told you that you had congestive heart failure?

BLCHF (1) Yes (0) No (8) Don't know (7) Refused

Were you hospitalized overnight for this problem?

BLHOMI3 (1) Yes (0) No → Go to Question #16

Complete a Health ABC Event Form(s), Section I, for each overnight hospitalization.
Record reference #'s below:

a. ☐☐☐☐☐ **BLREF15A**
b. ☐☐☐☐☐ **BLREF15B**
c. ☐☐☐☐☐ **BLREF15C**

Page Link # ☐

Version 2.0, 01/13/2000 pjm

Draft

16. Since we last spoke to you about 6 months ago, has a doctor told you that you had cancer? We are specifically interested in hearing about a cancer that your doctor diagnosed for the first time since we last spoke to you.

BLCHMGMT (1) Yes (0) No (8) Don't know (7) Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. | | | | | | **BLREF16A**

b. | | | | | | **BLREF16B**

c. | | | | | | **BLREF16C**

17. Since we last spoke to you about 6 months ago, has a doctor told you that you had pneumonia?

BLLCPNEU (1) Yes (0) No (8) Don't know (7) Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. | | | | | | **BLREF17A**

b. | | | | | | **BLREF17B**

c. | | | | | | **BLREF17C**

18. Since we last spoke to you about 6 months ago, have you been told by a doctor that you broke or fractured a bone(s)?

BLOSBR45 (1) Yes (0) No (8) Don't know (7) Refused

Complete a Health ABC Event Form(s), Section II, for each event.
Record reference #'s below:

a. | | | | | | **BLREF18A**

b. | | | | | | **BLREF18B**

c. | | | | | | **BLREF18C**

Page Link #

19. Were you hospitalized overnight for any other reasons since we last spoke to you about 6 months ago?

BLHOSP12 (1) Yes (0) No (8) Don't know (7) Refused

Complete a Health ABC Event Form(s), Section I, for each event.
Record reference #'s and reason for hospitalization below.

BLREF19A a. ☐☐☐☐☐ Reason for hospitalization: _____

BLREF19B b. ☐☐☐☐☐ Reason for hospitalization: _____

BLREF19C c. ☐☐☐☐☐ Reason for hospitalization: _____

BLREF19D d. ☐☐☐☐☐ Reason for hospitalization: _____

BLREF19E e. ☐☐☐☐☐ Reason for hospitalization: _____

BLREF19F f. ☐☐☐☐☐ Reason for hospitalization: _____

20. Have you had any same day outpatient surgery since we last spoke to you about 6 months ago?

BLOUTPA (1) Yes (0) No (8) Don't know (7) Refused

Was it for. . .?

Reference #'s

a. A procedure to open a blocked artery — (1) Yes (0) No (8) Don't know — **BLBLART** → ***Complete a Health ABC Event Form, Section III. Record reference #:*** ☐☐☐☐☐ **BLREF20A**

b. Gall bladder surgery — (1) Yes (0) No (8) Don't know — **BLGALLBL**

c. Cataract surgery — (1) Yes (0) No (8) Don't know — **BLCATAR**

d. Hernia repair — (1) Yes (0) No (8) Don't know — **BLHERN**

e. TURP (MEN ONLY) (transurethral resection of prostate) — (1) Yes (0) No (8) Don't know — **BLTURP**

f. Other — (1) Yes → (0) No (8) Don't know — **BLOTH**

Please specify the type of outpatient surgery.
i. _____
ii. _____
iii. _____

Page Link # ☐

Draft

21. Do you expect to move or have a different mailing address in the next 6 months?

Yes ① No ⓪ Don't know ⑧ Refused ⑦ **BLMOVE**

What will be your new mailing address?

New address:

Street Address Apt/Room

City State Zip Code

① Permanent address

BLADDRES ② Winter address

③ Other ***(Please describe:*** _____ ***)***

Telephone: ( ) _____

Area Code Number

BLMOVDA

Date new address/phone number effective: | | | / | | | / | | |

Month Day Year

Thank you very much for answering these questions. I enjoyed talking with you. Please remember to call us if you are admitted to a hospital or nursing home for any reason so that we can better understand changes in your health. We would also like to hear from you if you move or if your mailing address changes. I look forward to seeing you in the Health ABC clinic during your annual visit about 6 months from now.

Interviewer Note:
If participant reported having a cold or flu in the past 6 months that was bad enough to keep them in bed for all or most of the day AND they had a temperature of 100° or higher (refer to Question #6 on page 2), complete Substudy Workbook.

Page Link #